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Anna Alanko

IMPROVING MENTAL HEALTH CARE

Finnish mental health policy rationale
in the era of dehospitalisation

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Department of Social Studies
University of Helsinki
Finland

IMPROVING MENTAL HEALTH CARE

FINNISH MENTAL HEALTH POLICY RATIONALE IN THE ERA OF DEHOSPITALISATION

Anna Alanko

ACADEMIC DISSERTATION

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ABSTRACT

The study investigates policy level attempts to improve mental health care. It analyses the rationale of the proposals to improve Finnish mental health policy between 1964–2016. Such proposals have been presented in policy documents such as committee reports, working group memorandums, government bills and project reports. The most prominent examples of the improvement proposals are reducing psychiatric hospital care, increasing outpatient treatment, increasing the possibilities for mental health services users to work, emphasising the autonomy of the service users, and increasing the equal position of mental health care service users and other citizens.

The study seeks to find out what has been in the focus in reforming mental health care, how the people using mental health services have been perceived, and finally, what has been left unproblematised.

Since the late 1970s, Finnish mental health care has been subject to continuous reforms. A key feature of these reforms has been psychiatric dehospitalisation, i.e. reducing psychiatric hospital care. Dehospitalisation is a trend with complex origins, which became global after the Second World War and reached Finland by the mid-1970s.

Dehospitalisation stems from various and conflicting origins, such as citizens' rights movements, the development of the psychiatric profession, the economic interests of the state, as well as from pharmaceutical development. Dehospitalisation and mental health policy in general are deeply connected with welfare policy, but the relationship is not straightforward. In Finland dehospitalisation was planned as part of an expansive welfare policy, but its' implementation has sometimes recalled austerity politics.

Another phenomenon that affects mental health policy is the expansion of mental health care: the simultaneous increase in the provision, demand, methods and areas of jurisdiction of mental health care.

The dissertation shows that in the reform initiatives set forth in the policy documents, similar suggestions are given in different contexts.

In the analysed policy documents, dehospitalisation has been proposed as a solution to almost any problems perceived in mental health care. Dehospitalisation also seems to have materialised, as the number of psychiatric hospital beds is now many times lower than it was in the beginning of the period. Along with the diminishing number of hospital beds, new residential care facilities have been established which seem to be as institutionalising as the previous psychiatric hospitals. Also increasing the amount of outpatient treatment has materialised, but it seems that the services are used by a new group of citizens with milder problems. During the period between the 1960s and the early 1990s, those with a serious mental health problem were considered the core focus group of mental health policy, independently of whether they were within the labour market. Moreover,

providing sheltered work for those with serious problems was considered a method of rehabilitation.

After the mid-1990s the emphasis on paid work has increased. Those who are able to work in the labour market are the new focus group the mental health policy.

The pursuit of mental health care service users' increased autonomy is ideologically connected to the aim of dehospitalisation. However in the latter phases of the period, after the mid-1990s, the improvement suggestions start to assume the autonomy of the service users instead of seeking ways of supporting it. The changing understanding of autonomy also reflects to the notion of 'user expertise'. This recently emerged way of thinking lifts the expertise of people having experience with their own mental health problems. However the emphasis on 'expertise with experience' fails to take into account that there is a high demand for professional mental health services.

In the conclusions I argue that as a whole the well-meaning improvement proposals fail to problematise many structural factors contributing to the unequal provision of mental health care. Instead of achieving the revolving goal of increasing the equality of mental health care service users, the rationale has left room for excluding even further those with the most serious problems.

TIIVISTELMÄ

Mielenterveystyötä parantamassa. Suomalaisen mielenterveyspolitiikan perustelut sairaalahoidon vähentämisen aikakaudella.

Tutkimus tarkastelee valtionhallinnon tason pyrkimyksiä parantaa suomalaista mielenterveyden hoitoa. Työ keskittyy ajanjaksoon noin kuusikymmentäluvun puolivälistä tähän päivään, jolloin on pyritty psykiatrisen sairaalahoidon vähentämiseen. Ajanjakson aikana Suomessa on toiminut useita erilaisia hankkeita, joiden pyrkimyksenä on ollut suomalaisen mielenterveystyön kohentaminen. Tutkimuksessa analysoidaan näissä hankkeissa syntyneitä politiikkadokumentteja.

Pyrkimys vähentää psykiatrasta sairaalahoitoa on lähes kaikkialle länsimaihin levinnyt suuntaus, jolla on moninaiset juuret. Sen taustalla vaikuttavat niin kansalaisoikeusliikkeet, psykiatrian kehitys tieteenä, valtion taloudenpitoon liittyvät kysymykset kuin psyykenlääkkeiden kehityskin. Sairaalahoidon vähentäminen eli dehospitalisaatio ja mielenterveyspolitiikka ovat syvästi kytkeytyneet suomalaiseen hyvinvointipolitiikkaan. Suomessa dehospitalisaatiota suunniteltiin 1970–1980 -luvuilla, hyvinvointivaltion kulta-ajaksi ymmärretyn laajenevan hyvinvointivaltion aikana, mutta sairaalahoidon vähentämisen toteutus 1990-luvun jälkeen on paikoitellen muistuttanut niukkuuspolitiikkaa. Hyvinvointivaltion muutosten ja dehospitalisaation ohella mielenterveyspolitiikkaan on tutkimallani ajanjaksolla vaikuttanut mielenterveyspalveluiden käytön, kysynnän ja soveltamisalan laajeneminen, jota nimitän 'mielenterveystyön ekspansioksi'.

Tutkimuksessa kysytään: Mitä mielenterveyspolitiikan uudistuspyrkimyksissä on ehdotettu? Miten mielenterveyspalveluita käyttävät ihmiset on ehdotuksissa ymmärretty? Mikä parannusehdotuksissa ja toimintapolitiikoissa on jätetty huomiotta?

Tutkimuksessa osoitan, että mielenterveyden hoitoa kohentamaan pyrkineet hankkeet ovat kerta toisensa jälkeen päätyneet tekemään samankaltaisia ehdotuksia, kuten psykiatristen sairaalapaikkojen vähentäminen, avohoidon lisääminen, ja mielenterveyskuntoutujien työnteon lisääminen.

Samat ehdotukset ovat kuitenkin saaneet eri aikoina eri sisältöjä. Ajanjakson alkupäässä mielenterveyspolitiikan keskipisteessä olivat vakavasti sairaksi ymmärretyt ja se, miten heitä voidaan tukea elämään psykiatristen sairaaloiden ulkopuolella. Heille pyrittiin tarjoamaan kuntouttavaksi katsottua suojatyötä, mutta työssäkäyntiä ei sinänsä pidetty hoidon tai painatuksen ehtona. Nykyaikaa kohti tultaessa mielenterveystyön parantamiseksi tehdyissä hankkeissa painottui työkykyisten, lievästi mielenterveyden häiriöistä kärsivien mielenterveyden vaaliminen ja palkkatyön painotus mielenterveyspolitiikassa lisääntyi.

Analysoiduissa kehittämishankkeissa psykiatrisen sairaalahoidon vähentämistä ehdotetaan ratkaisuksi lähes mihin tahansa mielenterveystyössä havaittuun ongelmaan. Ehdotus näyttääkin toteutuneen, sillä psykiatristen sairaansijojen määrä on tällä hetkellä moninkertaisesti pienempi kuin se oli korkeimmillaan 1970 luvun puolivälissä. Kuitenkin samaan aikaan mielenterveyskuntoutujien asumispalveluiden käyttö on moninkertaistunut ja on kyseenalaista, onko mielenterveyskuntoutujien laitosmainen hoito vähentynyt merkittävästi. Myös toinen mielenterveyspolitiikkadokumenteissa toistuva tavoite, avohoidon lisääminen, näyttää toteutuneen. Mielenterveystyön ekspansioksi kutsumani ilmiön takia näitä palveluita käyttää myös uusi lievemmin oirehtiva väestönosa.

Hankkeet ovat julkilausutusti pyrkineet myös lisäämään tasa-arvoa mielenterveyskuntoutujien ja muiden kansalaisten välille. Johtopäätöksissä väitän, että nämä pyrkimykset epäonnistuvat siksi, että ne jättävät huomiotta niin rakenteellisia kuin puhe- ja ajattelutapoihin liittyviä seikkoja, joiden takia mielenterveyspalvelut jakautuvat eriarvoisesti.

ACKNOWLEDGEMENTS

A late evening, perhaps in 1987 when I was ten years old. My father is driving us to my grandparents' summer cottage. For some reason he ends up telling us stories about his and my mother's time as trainees in a psychiatric hospital in the early phases of their medical studies in the mid-seventies, which later turned out to be the period when the number of psychiatric hospital beds in Finland reached their peak. The story I remember most clearly was about a summer trip that included a boat excursion, which a group of patients made as part of their stay in the hospital. After the trip, my mother had asked one of the patients how things had gone. The patient had not exactly enjoyed the trip, because it had seemed to this person that knives were rising from the sea. In a way that I find very difficult to describe, the story made me feel both sad, as I realized the boat trip was meant to be nice and had turned into something frightening, and fascinated. I also remember wondering what my parents, who had ended up in completely different medical fields, were doing with these patients. Were they able to help?

Later, somewhere around the turn of the millennium, I remember walking with my friend in the University of Helsinki Centre campus area, probably before or after a lecture. We were talking about our troubles concerning things like studies, self-esteem and love. Having such trouble was, of course, quite common and revealing them was more or less non-stigmatising. Still, if severe enough, such preoccupations would often be diagnosed as depression and/or anxiety disorder. After a diagnosis, also help was available: the university students' health care fund offered the services of general practitioners, consulting psychologists and psychiatrists, as well as referrals to long-term psychotherapy subsidised by the Finnish Social Insurance Institution, abbreviated in Finnish as 'KELA'. Some services required a minimal fee, but most of them were free¹. Some of us were taking antidepressants, but my impression was that many more were seeing a therapist a few times a week. On that particular walk, my friend introduced me to what later became a key conundrum in my present work. She said, 'To get a couple of years of subsidized psychotherapy from KELA, one has to be crazy enough, but not too crazy'.

What happened later to the patient unable to enjoy the boat trip on the summer excursion because of the knives? Of course, I don't know. He or she may have eventually been discharged from the hospital. However, it seems more than likely that he or she never received a decision that KELA, or any other body, would pay her therapy a few times a week. He or she, to use my friends' expression, would probably have been perceived as *too crazy*.

¹'YTHS', 'Ylioppilaiden terveydenhoitosäätiö' as we knew it, was and still is easily accessible. YTHS offers services only to university students.

I am seriously indebted to many people for their help, support and inspiration. First, I thank my supervisors, Ilpo Helén and Anna Metteri. Ilpo first and foremost for inspiration, assiduous commenting, and for being alert to oversimplifications, which was a constant risk with a research topic such as the one chosen for this study. And Anna, both for comments on the theoretical approach and particularly on the pharmaceuticalisation of mental health care, but also for her unique ability as a former social worker to remind me of how these mental health policies have material consequences for real people, and it is for this reason that research is important.

Then the pre-examiners Katarina Piuva and Tuukka Tammi: I have absolutely never been as glad for any emails as those which included your statements. They were not only respectful, collegial, interested in the results of the study and constructive; you also sent them considerably earlier than expected. I also thank Tuukka Tammi for agreeing to go through the work once more in the public examination, as well the custos-to-be Anssi Peräkylä for taking this job and for his very calming presence in the preparations.

To mention a few other contributors: The key informants whom I interviewed at the beginning of this study allowed me invaluable knowledge and insight on mental health policy in Finland. This study has been made possible with funding from the SOTKA (*Sosiaali- ja terveydenhuollon, -politiikan ja talouden tutkijakoulu*) graduate school, two NordWel fellowships and the Finnish Academy project 'Public service provision between civil organisations and the new public management' led by Pekka Sulkunen.

I am grateful to Pekka Sulkunen for so many things, including inviting me to participate in the aforementioned project and also for the original idea that mental health problems are problems of agency, as well as for the fantastic, 'imPECCABLE' method of academic writing; without you I wouldn't know that an article has to contain a conflict, an instrument and a contribution, and after that it's only a matter of writing it down. Last but far from least, thank you for the numerous dinner parties.

One, of perhaps *the* best things that Pekka ever came up with has been the University of Helsinki Centre for Research on Addiction, Control and Governance (CEACG). I would like to thank in particular the current CEACG leader Matilda Hellman, who also is my co-author in substudy IV, as well as very particularly Anu Katainen, Riikka Perälä, Sanna Rönkä, Michael Egerer, Janne Nikkinen and Veera Kankainen, and also each of the following: Anna Leppo, Tuulia Lerkkanen, Emmi Kauppila, Riikka Kotanen, Virve Marionneau, Mirja Määttä, Yaira Obstbaum-Federley, Jussi Perälä, Arto Ruuska and Pauliina Seppälä. I have been with you longer than with my high school class, so I really don't know where to start. I'll begin with peer support, numerous constructive comments, inspiration from the studies you have been conducting, the lovely writing camps and lunches – and for never being able to proceed very far with the thought that I really would be all alone with this project.

I have also had the privilege, at a very early stage as a doctoral student, to join the network of welfare state historians within the Nordic Centre of Excellence, Nordwel, led by Pauli Kettunen and to participate in numerous seminars, conferences and summer schools and to receive two fellowships. I am most grateful that you allowed me to sneak into your discussions. This has allowed me a lot of perspective of how old the data analysed in this study actually is. In addition to Pauli, I have been inspired, helped, accommodated, fed and what not all over the Nordic countries among others by Helena Blomberg-Kroll, Nik Glover, Heidi Haggrén, Johannes Kananen, Christian Kroll, Chris Lloyd, Åsa Lundqvist, Carl Marklund, Sami Outinen, Joakim Palme, Saara Pellander, Klaus Petersen, Johanna Rainio-Niemi, Jussi Vauhkonen, Marjukka Weide and Mirja Österberg. It should also be added that half of the substudies belonging to this study are co-authored with NordWellians– thanks for the co-operation once more, Carl and Sami!

As a master's student, I was recruited for a research assistant position at The National Research and Development Centre ('Stakes'; now THL). This is where anything having to do with policy started, thanks to Meri Koivusalo, Eeva Ollila and Jonathan Tritter. Already in 2005 Meri was leading the avant-garde project discussing the manifestation of user involvement and patient choice in Finnish mental health care. These questions still are of extreme relevance now, over ten years later, to social and health care reform. Thanks also for the profound multidisciplinary built from the quite different fields of medicine and sociology, where also I got to know the great other Meri, Meri Larivaara, whom I also wish to thank for numerous discussions on mental health policy.

On returning from maternity leave in early 2015, I had the opportunity to join the COMP-seminar for three semesters. Thanks are due Lena Näre, Sirpa Wrede, Anastacia Diatlova, Daria Krivonos, Antero Olakivi: I could not possibly have had a better 'what's up, sociology' update than the one you gave!

I have also had two unofficial mentors over the years: My interest in studying mental health was piqued when I worked with Ilka Haarni in her project studying lay health and illness views as challenges for health care. I will always remember how much your encouragement meant to me as a bachelor's student when I had no idea of what I was doing. During recent years I have also had numerous long lunches with Urban Markström discussing mental health care reforms and psychiatry and making comparisons between Sweden and Finland, as well discussions about life and a particular flea market in Helsinki that his family loves. All or at least most of this was carried out in Swedish, which tells something about Urban's patience.

I also thank two very important friends and colleagues, Lotta Haikkola for a variety of matters so broad that I don't think I can remember them all: friendship, peer support, comments, editing, help in various computer problems as well childcare. And another Lotta, Lotta Hautamäki for knowing and sharing everything on mental health, mental health care and governmentality studies over all these years and very recently, reading and

commenting this work last time two days before print and suggesting only a do-able amount of alterations – as well as the promise to coach me for the public defence.

Outside the immediate sociology environment I want to express gratitude to Kerttu Aitola, Heidi af Heurlin, Heidi Härkönen, Päivi Karhio-Szilvay, Marjut Lovio, Johanna Lukkarila, Saskia Mattila, Heidi Simomaa, Mika Turkia, Riikka Suominen and Laura Ukkonen for friendship and greetings from outside the ‘box’.

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I thank my own parents, Arto Alanko and Satu Jäntti-Alanko most for love, encouragement, but also the constant presence of the fields of medicine, health policy and literature at the dinner table. My interest in healthcare and writing stems from there of course. And to my siblings, Leena and Olli, plus Olli’s whole family, for sharing both the starting point and much of our everyday lives today – like when exchanging views on sociology of health and illness with Leena or on the best swimming pool in town for kids with Olli.

Then, dearest of all, the people I live with: I thank my husband, Christer, for love, friendship, for mostly being there but also for sometimes going away, and your endless interest in every social phenomenon that has inspired me a lot over the years. You are also the funniest person in the world. Moreover, I am really grateful for a massive amount of proofreading and computer help, all the headphones you have bought me to help me concentrate, and for the beautiful cover picture of this book.

Finally, I am out of words how to thank you Aura, my sunshine, now three (‘And a half!’, you would add) years old. If I would be as energetic and witty as you are, I’d have solved Finnish mental health issues already! I am also very grateful for all those times you sat peacefully in my office watching cartoons when I was making the last revisions, and still always liked coming to my office.

I dedicate this book to the memory of my grandmother, dentist Leena-Maija Jäntti, née Kuuskoski (1911–2007), who always encouraged women to pursue higher education. I don’t think I am able to assess how much that has meant.

At my grandparents’ dinner table in Lauttasaari, which today is my home,
August 2017

Anna Alanko

CONTENTS

List of original publications	12
1 Introduction.....	14
2 Psychiatric dehospitalisation and Nordic welfare state reforms	19
2.1 Psychiatric dehospitalisation.....	19
2.1.1 Psychiatric dehospitalisation in Finland	21
2.2 The welfare state in Finland	25
2.3 Summary on dehospitalisation and welfare reforms	28
3 The expansion of mental health care	30
3.1 The expansion in numbers	31
3.2 Accounts of the expansion	32
3.3 Summary on the expansion of mental health care.....	35
4 Theoretical and methodological starting points	36
5 Data and analysis.....	38
6 Substudies.....	42
6.1 Substudy I: ‘Who needs mental health services?’	42
6.2 Substudy II: ‘From a virtuous circle to an autonomous life’ ..	43
6.3 Substudy III: ‘Dualising activation’	44
6.4 Substudy IV: ‘Service users and experts’	45
7 Results: Revolving proposals to improve mental health care	47
8 Conclusions: A need for protection from abandonment?.....	51
References	54

LIST OF ORIGINAL PUBLICATIONS

This thesis is based on the following publications:

I Substudy I Alanko, Anna & Carl Marklund (2013). 'Who needs mental health services? The aims and service user images in Finnish mental health care planning', in Marklund, Carl (ed.) *All Well in the Welfare State? Mental wellbeing and the politics of happiness*. NordWel Studies in Historical Welfare State Research, pp. 82–102.

II Alanko, Anna (2015). 'Hyvältä kehältä autonomiseen elämään' ['A virtuous circle for an autonomous life'], in Autto, Janne & Mikael Nygård (eds.) *Hyvinvointivaltion kulttuurintutkimus* [Cultural studies of the welfare state]. Rovaniemi: Lapland University Press, pp. 167–195.

III Alanko, Anna & Sami Outinen (2016). 'Dualising Activation: Responses to unemployment and mental health-related disability retirement in Finland at the turn of the millennium'. *European Societies* 18:5, 417–437.

IV Alanko, Anna & Matilda Hellman (2017, forthcoming). 'Service users and experts in Finnish mental health policies: Three phases of expansion and inclusion'. *Sociologia* 54:4.

The publications are referred to in the text by their roman numerals.

1 INTRODUCTION

This doctoral dissertation analyses mental health policy and its rationale in Finland during a period when the policy was actively endeavouring to minimise psychiatric hospital treatment. This period spans the mid-1960s to the present. During this time, mental health care in Finland and official policy have witnessed continuous change, with the main goal being to reorganise mental health care to meet the needs of the population.²

The study approaches the rationale of Finland's mental health policy both on a general level (Substudies I and IV) as well as through policies focusing on particular issues (Substudies II and III). The total data set consists of mental health care policy documents, some of which discuss mental health policy on a general level and some of which represent two particular projects. These two projects each address a particular problem in mental health care: the first 'developing the treatment and rehabilitation of schizophrenia' (Substudy II) and the second 'avoiding early retirement associated with depression' (Substudy III). Most of the documents were drawn up by policy working groups whose members had been appointed to represent various professions and societal sectors, from research to clinical work and from civil servants to non-governmental organizations. The study contextualises the rationales expressed in mental health policy in the context of a fluctuating overall welfare policy.

During the period analysed, Finland witnessed the building and expansion of the Nordic welfare state, a recession combined with changes in the welfare policy and finally, a period of 'permanent austerity' (Hiilamo 2014) during which welfare expenses were constrained independent of the economic situation. In the area of mental health care the most important and obvious changes that occurred were an overall trend towards dehospitalisation (Section 2) and an expansion of the demand for, use, provision and jurisdiction of mental health care (Section 3).

The study seeks a rationale for the policy reform proposals on how mental health care should be improved. This search was carried out in the four substudies, which together make up the dissertation. The *first* substudy analyses general level mental health policy documents between 1977, the starting point of the reductions, and 2009. Its goal is to identify the intent of the policy documents and how the service users have been perceived. The *second* substudy analyses a national programme carried out during the 1980s

² By mental health care I refer to all work intended to take care of the population's mental health, including treatment, rehabilitation and planning (cf. footnote on 1 p. 82 in Substudy I). This field comprises the work of many professions, but this study has given particular attention to the specialty of psychiatry. In the beginning of the period analysed, mental health care was mostly the work of psychiatrists.

to prevent the long-term hospitalisation of patients diagnosed as suffering from schizophrenia and reflects the project's early aim of independent living of those patients diagnosed with schizophrenia by comparison with today's idea of citizens' autonomy. The *third* substudy analyses policies targeting two administrative categories of non-working populations, namely the unemployed and those retiring early for mental health-related reasons. The study discusses the categories of the 'unemployed' and those on 'disability pension' on a continuum rather than as being fundamentally different. The *fourth* substudy analyses the conception of 'expertise', again based on Finnish general level mental health policy documents, this time from 1964, when ideas of the importance of patients' own interpretations of their conditions started to emerge, up to 2016. This analysis reveals how expert opinions have varied over time, from an emphasis on the psychiatric profession in the beginning to deprofessionalisation in the middle phase and finally to the emphasis on 'user experts' in the most recent phase. The article discusses the paradox that the importance of 'user expertise' emerges during a period of a high demand for professional mental health care.

A core question in the policy rationale is the perception of the service users, the people who are thought to use the mental health care that is planned in mental health policy. How the potential user group is understood mirrors how the need for services is perceived. In other words, the understanding of the service users reflects to both what kind and how much mental health care is perceived as adequate. This has been articulated primarily in attempts to replace hospital treatment with outpatient treatment.

The study employs the concept of a 'citizen' of the population discussed in the policy documents. In Finland the entitlement to health care is based on residence, not citizenship, so very strictly speaking 'resident' would sometimes be more correct. However, the concept of citizenship has been frequently used in discussing the relationship of health care and the welfare state. This study aims to connect to these discussions in terms of analysing the relationship between the individual, the welfare system and the modes of governing (for example, Helén & Jauho 2003, Clarke 2005; Koivusalo, Ollila & Alanko 2009; Newman & Clarke 2009). Citizenship of people with mental health conditions has also been discussed as particularly complex; on the one hand, people with mental health conditions should have the same rights as others, yet on the other hand they may still need particular protection related to their mental health condition (e.g. Perron, Rudge & Holmes 2010; Hazelton & Clinton 2002).

The study also employs the concept of the 'service user' to refer to those who are using the mental health services. The notion of this group has varied, and previous studies have paid attention to a shift from patient to 'customer' or 'client' (e.g. Helén 2011a, Koivusalo, Ollila & Alanko 2009). With the idea of the service user, the study attempts to find a concept which serves to address the same group throughout the analysis period. However, the study does not directly belong to the tradition of service user involvement or movement

studies, which are, however, discussed as an essential element of the changing policy rationale in Substudy IV. While the current study focuses on mental health policy and its rationale, the tradition focusing on service users discusses the experiences of people with mental health problems in the care system (e.g. Wallcraft & Bryant 2003; Beresford 2005; Bracken & Thomas 2013; Markström & Karlsson 2013).

The notion of what ‘needs’ for mental health care were to be taken care of appeared to be key for grasping what a given policy was intended to accomplish. The representation of the service user and the service users’ potential needs or capacities is perceived to be at the heart of policy rationale. The approach focuses on the kinds of subjects represented in and enabled in mental health policy proposals, and it is influenced by governmentality literature (e.g. Foucault 1991a; b; Rose 1999b; Helén 2016; methodologically, Bacchi 2009). As for the question of modes of governing, the analysis is concerned with ideas of the citizen autonomy as discussed by the sociologist Pekka Sulkunen (2009; 2016). The rethinking of needs is a powerful tool in altering policymaking, as the aim of the policy is to plan how to provide what is needed.

Undoubtedly, planning the service provisions according to ‘needs’ seems a natural rationale in all social policies. Need is also a notion used as a basis for legislation, ensuring that the collective solutions decided on are justified by people’s interests: Finnish municipalities have a statutory obligation to fulfil ‘the needs of the municipality’ in terms of service provision to their residents (Mental Health Act 1990/1991). This study, however, shows that the understanding of the notion of a need for mental health care has been perceived very differently at different times. Both the character and the amount of what has been perceived to be the need for service provision has changed enormously during the period analysed, 1964–2016. The focus is on the perceptions of the mental health care service users as represented in the policy documents and their perceived needs, primarily with regard to support measures and services.

A quantifiable example of the shifting understanding of needs is the number of psychiatric hospital beds: today that number has decreased to approximately 15 per cent from its peak in 1976 (Järvelin 2016; Koskinen 1994). Reducing ‘unnecessary’ psychiatric hospital treatment was the central aim in the policy proposals. The idea of the number of hospital beds that were ‘needed’, however, changed dramatically: the number fell drastically, but it was still constantly perceived as excessive. The phenomenon of downsizing psychiatric hospitals, referred to as deinstitutionalisation or dehospitalisation, has been examined in numerous studies, both nationally and internationally (see subsection 2.2). Dehospitalisation also constituted a natural starting point for the current study, as it was a major global trend in mental health care during the period being studied.

This dissertation reflects the mental health policy rationale in relation to a Nordic welfare state policy. The Nordic welfare states have typically aimed for

universalism, accessible and equal health care and citizens' entitlement to public support for those unable to sustain themselves on the labour market,³ despite the welfare state reforms during and after the 1990s (e.g. Hellman, Monni & Alanko 2017, *forthcoming*). The theoretical and methodological starting points for the study draw on traditions, which have analysed the welfare state from a cultural perspective (Autto & Nygård 2015).

The following questions underpin the study's inquiries:

- I. What measures have been proposed to improve Finnish mental health care? What kind of 'problem' representations do the policy proposals, i.e. improvement proposals, reflect?
- II. How are service users characterised in the plans?
- III. Who are seen as 'experts' in mental health care?

The dissertation is based on an analysis of Finnish governmental-level mental health policy documents.⁴ The data were chosen because these policy documents reflect the aims and rationales of mental health policies at the time these documents were written and published. The documents are evidence of publicly-appointed planning, which was to take into consideration the political and societal context of the time. Four key informant interviews were also conducted, which had a remarkable impact on how the data were read. The data will be discussed in detail in section 5.

The dissertation shows that in mental health policy during the period analysed, similar suggestions were presented in different welfare state contexts, and the overall welfare policy affects how seemingly similar solutions turn out.

First, the mental health care policy proposals have consistently suggested psychiatric dehospitalisation as a solution to almost any problem in mental health care during these years, even at the end of the studied period when the number of hospital beds was but a fraction compared to the situation in the mid-1970s. The number today is many times lower than what was planned when the dehospitalisation was initiated, and hence it is of interest that the rationale tends to perceive that there are always excessive numbers of psychiatric hospital beds that can be reduced.

Second, the analysed policy documents have repeatedly emphasised that the participation in working life of those suffering from mental health problems should be actively encouraged. This aspiration was first expressed in times an expanding welfare state, and, as shown in the data, in the proposals from the 1970s and 1980s the proposal included the idea to create sheltered

³ Gösta Esping-Andersen (1990) uses the term 'decommodification'.

⁴ Although the health and social care service provision is the responsibility of municipalities (which is currently under reform, Kalliomaa-Puha & Kangas 2016), the study focuses on the governmental level, which is responsible for 'the general planning, direction and supervision of mental health work' (Mental Health Act 1990).

jobs for those unable to succeed in a competitive labour market. The aspiration becomes very different in times with conflicting tendencies in allowing a large number of disability retirements as a solution to the low demand for the labour force of people with mental health issues and simultaneous elements of 'dualisation'⁵ and 'workfare'.⁶ Emphasising the employability of people suffering from mental health problems enables a rationale whereby support is provided on unequal terms according to employability.

Third, the plans have endeavoured to promote the autonomy of service users, while at the same time, that autonomy has been used as a concrete conceptual planning tool, particularly in decreasing the number of psychiatric hospital beds. The notion has enabled not only cutting down on institutional treatment (more rapidly than the pace originally calculated, as already mentioned), but also shifted the focus of mental health policy from the treatment of those considered ill to supporting the health of those perceived to be healthy. This enabled downplaying the needs of those perceived to be ill.

Fourth, the notion of citizens' inherent autonomy seems to have enabled a renegotiation of the previous position of mental health care professionals as experts in favour of users' experiences being considered as 'expertise'. The policy rationale however fails to problematise that the role of an 'user expert' is offered to those in a marginalised position, and that at the same time there is a high demand for professional mental health care.

This conclusive chapter proceeds as follows: in the next section I will discuss two global relatively established phenomena, psychiatric dehospitalisation and welfare state reforms. In section three, I am discussing another global contextual phenomenon which however is less established, that of the expansion of mental health care. In section four I will discuss the theoretical and methodological starting points. Section five presents the primary data consisting of Finnish mental health policy documents and four key informant interviews that have been used as a background data. Section six presents the four peer-reviewed articles that form the substudies of this dissertation. Section seven summarises the results of the study and section eight presents the concluding remarks.

⁵ On differentiating the provision of welfare according to the citizens' position on the labour market, see Substudy III.

⁶ Conditioning the provision of welfare services and benefits on work performances as opposed to providing welfare according to the individuals' needs.

2 PSYCHIATRIC DEHOSPITALISATION AND NORDIC WELFARE STATE REFORMS

There are two immensely important historical circumstances that provide the backdrop to this dissertation. First, there has been a general dehospitalisation trend in mental health care service provisions globally by which I am referring to a shift from large-scale institutionalising of those with mental illness to the idea that these patients would do better outside hospitals. At the same time, another crucial factor are the establishing and the reforms of the Nordic welfare state and particularly Finland. During the analysed period Finland has developed to first an 'expansionist' (1960 to 1990) to a 'post-expansionist' (mid 1990s) society and finally after the millennium to a 'permanent austerity' system. The change after the mid-1990s should not be exaggerated as the Finnish welfare system still aims to universally all citizens and guarantee their social rights, among which the development of social and health care has been most crucial for the current study (e.g. Hiilamo 2014; Julkunen 2001; Kettunen 2001; Hellman, Monni & Alanko 2017 *forthcoming*). Both circumstances have attracted a great deal of interest in previous studies to the point that the trends can even be considered common knowledge.

This section discusses these two phenomena in the light of previous research. The section concludes by discussing the interaction of these two phenomena and emphasises that psychiatric dehospitalisation is a broad phenomenon with multiple origins. Even if mental health policy is affected by the general welfare policies (Goodwin 1997; Carpenter 2000; Melke 2010), psychiatric dehospitalisation should not be equated with welfare state retrenchment. Still, mental health policy may contain elements of post-expansive and austerity policies.

2.1 PSYCHIATRIC DEHOSPITALISATION

Psychiatric dehospitalisation, the aim of reducing psychiatric hospital treatment, has been a global trend in psychiatric care and has been going on since the Second World War, particularly in the late 20th century (e.g. Goodwin 1997; Shorter 1998; Melke 2010). It can be said that the amount and the lengths of psychiatric hospital treatment have gone down everywhere and that national legislations have been altered to emphasise outpatient instead of inpatient treatment. Examples of such legislations are the National Mental Health Act (1946) and the Community Mental Health Act 1963 in the US; the Mental Health Act (1959) in the UK; and the often discussed Italian 'Law 180' from 1978, which abolished psychiatric hospitals altogether. Finland was a latecomer to this development, as the number of psychiatric hospital beds only

started to accelerate at a time when they had begun to diminish elsewhere. Finland also outspokenly followed international examples (cf. Substudy I, NBoH 1977; CR 1984).

A core origin of the dehospitalisation policy has been the ideology of avoiding unnecessary seclusion, which *per se* is seen as harmful to mental health. Criticism of the negative effects of psychiatric hospital care were presented as early as the 19th century (e.g. Scull 1984, Castel, Castel & Lowell 1984). However, the remarkable global trend of avoiding psychiatric hospital care stems from the breakthrough in treating mental health patients outside asylums, which began in the 1950s in the Anglo-American world. The WHO was one of the early promulgators of dehospitalisation (e.g. Novella 2008; Henckes 2009; Eskola 2007).

Multiple key factors have been advanced for dehospitalisation, such as the need to renovate asylum buildings, broader citizens' rights movements, the interests and professionalization of the psychiatric profession, the development of antipsychotic drugs and the fiscal interests of states. There is, however, some consensus regarding the fact that there were no single advances in psychiatry; not even the development of the antipsychotic drug chlorpromazine in the 1950s alone would explain the development. (See, e.g. Novella 2008; Berks 2005; however, for a contrary interpretation highlighting the development of pharmaceuticals, see Shorter 1998).

Presenting a detailed, but global view on the development seems nearly impossible. The history of psychiatry is filled with profoundly different interpretations, and it seems that most accounts are incompatible (on the different interpretations of the historiographies of psychiatry on a meta-level, see e.g. Berks 2005; Novella 2008; 2010; Scull 1999).

An essential difference has to do with whether or not an account accepts that psychiatric dehospitalisation or psychiatric hospital discharges increase the freedom of former hospital patients. To avoid this equation, this study uses the concept of dehospitalisation rather than the more commonly used 'deinstitutionalisation'. Some accounts seem to equate 'deinstitutionalisation' with the diminishing number of hospital beds (e.g. Mechanic & Rochefort 1990, Grob 1991; Goodwin 1997; Shorter 1998). The above accounts seem to discuss 'deinstitutionalisation' as a benevolent project, but its implementation is complicated and defective. While, notably, none of the above accounts considered the implementation of deinstitutionalisation to have been successful (at least not unambiguously), they seem to argue that the phenomenon has occurred and that deinstitutionalisation would be possible if only adequate services could be provided for the 'deinstitutionalised' population.

There is also another legacy of the literature on the demise of psychiatric hospital care, which questions the whole concept of deinstitutionalisation and which does not perceive any less use of subordinating power in the arrangements after the mass hospital discharges (Scull 1984; Castel, Castel & Lowell 1982; Estroff 1985; Barham 1997). Independent of whether the

accounts believe in the capacity of potentially increasing freedom, the implementation of dehospitalisation has been criticized in all the studies mentioned here. Not depending on the context, it is agreed that the way dehospitalisation has been implemented has not benefited the least capable former hospital patients and that serious issues remain in how to provide adequate support for former hospital patients. Concern has also been raised about ‘reinstitutionalisation’ and/or ‘transinstitutionalisation’ of former hospital patients to different, but not necessarily less institutional residential care facilities and even prisons (e.g. Priebe et al. 2005; Wahlbeck et al. 2017; cf. below).

2.1.1 PSYCHIATRIC DEHOSPITALISATION IN FINLAND

The Finnish psychiatric hospital system had been established during the late 18th century with the first Finnish asylum at the Seili Hospital. Originally a hospital for lepers, Seili became a state mental institution in practice in 1755 (Ahlbeck-Rehn 2006) and officially in 1771 (Mäkelä 2008, 32). The first decree regulating mental health care appeared in 1840, and the first Mental Illness Act appeared in 1937. In the beginning, the Finnish state was responsible for mental health care, but with the Mental Illness Act of 1952, the task was divided so that the state was responsible for the planning, but the responsibility for organising the services shifted to the municipalities. The Mental Illness Act led to a rapid growth in the number of psychiatric hospital beds (e.g. Hyvönen 2008). The very first task undertaken by the working groups whose documents are analysed in this study was to amend the Mental Illness Act.⁷

In Finland, as well as in other Nordic countries (Carpenter 2000; Markström 2003; Lindqvist et al. 2011; Piuva 2005; 2013), aspirations towards psychiatric dehospitalisation emerged relatively late. Even though the international discussion opposing institutional treatment in the name of civil rights had reached Finland in the 1960s, the psychiatric dehospitalisation policy only started in the late 1970s. The first steps in dehospitalisation were in Finland underpinned by thorough, state-level plans, which are analysed in the current study. They relied to a great degree on experiences from other western countries and transnational trends (see section 5, which presents the data used in the current study). The hospital bed reductions that were laid out in the original plans published in the late 1970s and mid-1980s had already been realised by the end of the year 1991, before economic recession hit the

⁷ The committee report from 1964 suggested replacing the term ‘illness’ with ‘health’. This suggestion has materialized today, but it was only enacted in 1991; see Mental Health Act 1991; Substudy I, Substudy IV.

country. Nonetheless, as I will discuss below, the reductions have continued up to the present time.

A radical civil rights movement called the 'November Movement' (1967–72) launched the first criticisms of how the 'deviant' were treated in institutions in Finland. The criticism was not restricted to the treatment of psychiatric patients, but originated in a more comprehensive and highly critical view of institutional treatment of psychiatric patients and inmates as well as the homeless in Finland. The November Movement objected to keeping people stigmatized as 'deviant' in different institutions, not only those in psychiatric hospitals, but also prison inmates along with the treatment of the homeless (Niemelä 2003; Sulkunen 2011). The movement was strongly influenced by the works of the sociologist Erving Goffman and particularly the concept of 'institutionalisation', which referred to the negative effects of institutional treatment (Niemelä 2003; Goffman 1961). The November Movement can be seen in an international source of criticism of psychiatric care, which has been referred to as critical or anti-psychiatry (for example, Hopton 2006; Hyvönen 2008; in Sweden, Ohlsson 2008). It also reflects a broader liberal movement typical of the time (e.g. Sulkunen 2009; 2011; 2016). Another field which emerged during the same period, but this time within psychiatry, was social psychiatry, which highlighted the influence of the environment on mental health problems. The field of social psychiatry was founded on the disciplines of psychiatric epidemiology, social sciences and public health rather than on radicalism (Fleck 1990; Lehtinen & Suominen 1983; Anttinen 1983; Lehtinen 1983; Piuva 2005).

According to these paradigms, psychiatric problems were perceived as essentially social rather than individual. Treating individuals in institutions was understood as harmful, as it was understood that the mentally ill were made ill by the society and especially by the mental health treatment in psychiatric hospitals. Such discussion still continues today: for example, Moncrieff and Middleton (2015; see also Moncrieff 2010) argue that patients would do better without psychiatric diagnoses, particularly the diagnosis of schizophrenia, which is seen to lack benefits in terms of guiding the aetiology or the treatment, but yet they argue that such diagnoses cause stigmatisation.

Even though the November Movement was active for only a few years, its importance can be considered as having lasted longer, because part of the reason for its disintegration was that its members began to work for the Finnish civil service. It is generally believed that the thinking of this radical movement had become normalised to the point that it could continue as part of the public administration after the early 1970s. As a result, the official welfare policies also started to reflect radical reformist views. (Niemelä 2003; Honkala 2011; Salo 1996.)

Rehabilitation, today a mainstream concept in mental health care, emerged in Finnish psychiatric thought in the 1960s (Salo 1996, 200–236). Instead of thinking of mental illness as a long-term or even life-long fate, this concept meant taking the attitude that patients should be given an opportunity to

rehabilitate. This change in thinking affected the content and the length of psychiatric treatment, as mental health problems were not thought of as lasting a lifetime. Instead, social interventions such as reducing poverty were seen as ways of affecting the population's mental health. However, it has been pointed out that the social psychiatric aspect of dehospitalisation has increasingly given way today to pharmaceutical treatment, which neglects the role of the environment in mental health problems (Helén, Hämäläinen & Metteri 2011).

The lack of comparable statistics prevents giving an exact number of how much psychiatric hospital care has been reduced, but the most usual estimate is a reduction of 85 per cent. Indicators used are the numbers of hospital beds reported in official Finnish statistics (Järvelin 2016; Koskinen 1994). A second indicator is the shortening of the treatment period; in Finland the average duration of treatment periods has been reduced considerably (Statistical Yearbook Finland 2016, 310; Karlsson & Wahlbeck 2011; Korkeila 1998). A third measure is estimating the numbers of hospital beds removed: according to Nenonen et al. (2001), between 1970 and 2000 by a rough estimate, 14,000 patient beds had been removed from the psychiatric care system.

It has, however, been pointed out that the number of persons treated in psychiatric hospitals was not affected as much as the length of the treatment periods (Korkeila 1998). In number of hospital beds per resident – a number which is internationally comparable – the respective numbers were approximately 4.2 per thousand residents in the late 1970s (see, for example, Korkeila & Tuori 1996) and approximately 0.6 per 1,000 residents in 2014.⁸

In other words, the dehospitalisation policy has shortened the treatment periods, but has not reduced psychiatric hospital admissions to the same degree. Another factor that affects dehospitalisation is that it seems that the number of inhabitants in residential care facilities for psychiatric patients has grown simultaneously with the decreasing number of psychiatric hospital beds. The number of inhabitants in residential care facilities today is around 8,000, that is, two-fifths of the total number of psychiatric hospital beds at its highest in the late 1970s (Sotkanet 2017; Koskinen 1994). These facilities have been criticised for their institutionalising character, the lack of basic rights like inviting guests to stay over and for the lack of available health care services (Salo 2017; *Helsingin sanomat* 18 October 2015; Vihreä Lanka 2017).

After the mid-1990s, public criticism of mental health care continued, but the main target of criticism has been the way in which dehospitalisation has been carried out. In the international discussion on psychiatric dehospitalisation, it has often been pointed out that the implementation has given the neediest the least attention (for example, Grob 1991). In Finland this argument has peculiarities related to its national context. In both policy and research discussions about mental health care today, it is often said that due

⁸ The author's calculation is based on figures in psychiatric hospital care days given by Järvelin 2016.

to the Finnish recession of the 1990s, outpatient care is insufficient and lacks resources (e.g. Eskola 2007). An early study on the effects of dehospitalisation was conducted in the municipality of Helsinki, and the results showed that the patients discharged between 1987 and 1991 had an unusually high risk of either being readmitted to a psychiatric hospital or dying (Wahlberg & Sohlman 1993). Moreover, a register study on the use of psychiatric hospitals between 1991 and 1996 showed that the treatment correlated strongly with education, the least educated being more often admitted to hospital under a psychiatric diagnosis, but the more educated, who received longer treatment, were more likely to receive psychiatric specialist treatment and treatment in either private or the most highly esteemed university hospitals. Hence, it appeared that the least educated were at risk of a so-called revolving-door syndrome, i.e. being repeatedly admitted for short treatment periods without follow-up when discharged, and that the disadvantaged social position had not been paid adequate attention. The study also showed that the socioeconomic gradient grew between the early and the mid-nineties. (Ostamo et al. 2005.)

Many previous studies have noted that the development of mental health care and policy after the 1980s seems, in many respects, to be a result of the unplanned consequences of reforms conducted in the broader welfare and health care arrangements. The perceived shortcomings have been explained as resulting from a discrepancy between the planning of dehospitalisation during the era of the expansive welfare state and the execution of dehospitalisation in the post-expansive welfare state context. It has also been argued that there has been a significant discontinuity in Finland in the planning and execution of dehospitalisation between the early period (1970s–80s) and the time from the 1990s onwards. (Eskola 2007; Helén 2011a; Helén, Hämäläinen & Metteri 2011; Hyvönen 2008; Karlsson & Wahlbeck 2012; Öhman 2003).

The Finnish dehospitalisation reform has also been criticised for being insufficiently carried out and treatment as still being too much attached to and based on institutions (Wahlbeck 2007; Salo 1996). On the other hand, the success of dehospitalisation has been measured, for example, by the number of suicides after hospital release. In these terms dehospitalisation seems to have proven successful, as suicides of previously hospitalised patients have not increased (Pirkola et al. 2007). It has also been concluded that, even though the mortality rate of people suffering from serious mental disorders remains considerably higher than that of the average population, this is not because of dehospitalisation (Westman, Gissler & Wahlbeck 2011). However, the excess mortality of psychiatric patients has continued up to the present time, a figure pointed out as being on an alarming level (see, for example, Nordentoft et al., 2013; Wahlbeck et al., 2011).

In international comparisons the Finnish dehospitalisation storyline contains both similar and dissimilar elements. First, the point of departure and the pace of change were both rather extraordinary; having started from the work of a radical movement, perhaps it could have been expected that

dehospitalisation would emphasise citizens' rights (for such an hypothesis, see Carpenter 2000). Before dehospitalisation began, Finland had a large number of psychiatric hospital beds per inhabitant, perhaps the highest in the world (although the same has been claimed about Sweden; e.g. Melke 2010). Partly owing to this circumstance, the number of psychiatric hospitals in Finland decreased rapidly (Knapp et al. 2007, 167). Second, partly due to the November Movement (but perhaps also to a general leftist orientation among civil servants), many Finnish civil servants in key positions, especially those active in the early and the mid-period of this study, had a background in or were influenced by radical civil society organisations that criticised institutional treatment. Hence, the thinking adopted on the Finnish state level has somewhat reflected this sort of civil society activism. (See Substudies I and IV.) Third, while a considerable proportion of the reductions in psychiatric hospital beds took place during a dire economic crisis during the early 1990s, the policy had been planned during the period when the welfare state was expanding.

The hegemony of the need to reduce the number of psychiatric hospital beds is nevertheless very strong. Despite the constant criticism of various aspects of dehospitalisation, it is still largely perceived as the only alternative; as one review states, 'a change in course has not often been uttered' (Karlsson & Wahlbeck 2011, 67).

Despite the consensus of the need to reduce psychiatric hospital beds, a critical discussion about the interaction between the psychiatric hospital discharges and the prison population has recently strengthened. In this discussion the main argument is that the inadequate support in the outpatient system has collided with dehospitalisation, leading those with severe mental health problems to commit crimes and end up in prisons. This is both a Finnish and an international concern (Sisti, Segal & Emanuel 2015; Lamb & Weinberger 2016; for criticism, Ben-Moshe 2017; in Finland, Jüriloo, Pesonen & Lauerma 2017).

2.2 THE WELFARE STATE IN FINLAND

Mental health policy and planning are part of Finland's welfare policy, which adheres to the basic principles of the Nordic welfare state. Typical features of the Nordic welfare states are the goals of universalism, 'decommodification',⁹ public or publicly-funded health and social care provision and an overall attempt to increase equality. Moreover, the Nordic welfare states also practise active labour market policies, rely on expert knowledge and tend to have high

⁹ The concept of 'decommodification' refers to the possibility of receiving welfare services and benefits independent of one's position in the labour market. The paradigmatic example is a situation whereby citizens are temporarily outside the labour market primarily in circumstances of unemployment and receive public subsidy. (Esping-Andersen 1990; Kettunen 2010).

rates of income tax and likewise high levels of public spending (e.g. Kautto et al. 2001; Christensen & Markkola 2006; Kildal & Kuhnle 2006 a; b; Metteri 2012; Lundqvist & Petersen 2010; Hellman, Monni & Alanko 2017 *forthcoming*). The principle of universalism is perhaps the most crucial (Kildal & Kuhnle 2006 b). The notion of universalism refers to the idea that the welfare system serves all citizens, not only those with the lowest income, but special treatment may be offered to those in the greatest need (Halmetoja 2015).

In the context of the current study, a remarkable paradox in the Finnish welfare system is that, while it aims to distribute welfare evenly, it has not succeeded in providing equal health outcomes (Rahkonen & Lahelma 2010; Palosuo et al (eds.) 2007; Bambra 2012). In fact, inequality in the Nordic welfare states seems to be increasing (Kvist et al. 2012). It has frequently been pointed out that if tendencies towards marketisation of welfare services and the provision of welfare according to 'workfare' principles increase, such developments will amplify further the trend of widening gaps between different socio-economic groups (e.g. Bambra 2012; Jutila 2011; Sorsa 2011).

The development towards the Nordic welfare model started later in Finland than in the other Nordic countries, and it is often pointed out that the Finnish system follows Nordic principles less than Sweden, for example (e.g. Julkunen 2006; Sorsa 2011). Depending on the interpretation, the starting point of the Finnish welfare state can be found in the other Nordic countries either before the Second World War, when the welfare state principles were articulated and universal coverage was made available, or at least by the 1960s, when public services began to spread (Kvist et al. 2012; Hellman, Monni & Alanko 2017 *forthcoming*). In Finland, the measures that eventually formed the first steps towards this welfare model before the 1950s involved old-age pension (1949) and a universal child benefit to all families with minors (1948), but the country's more accelerated development towards this model has often been dated to the early 1960s when the Health Insurance Act (1964) was passed (Kettunen 2001).

The earliest mental health policy proposals analysed in this study date back to 1964. By this time, the welfare state project was already under construction, and hence the data used here can be interpreted as part of the larger project of Finland as a Nordic welfare state. The 'golden years' of the (Nordic) welfare states were times of economic expansion coupled with enlargement of the public sector. The expansive welfare state period in Finland spanned the 1960s to the early 1990s. It was easy to identify this period in the data analysed for this study; the policy documents, especially from the 1980s, suggested straightforward increases in services and spending, whereas after the 1990s in the contexts of the 'post-expansive' and particularly the 'permanent austerity' policies, measures that would have led to rising costs were not even suggested.

After the beginning of the 1990s, following the Nordic welfare state principles became more complicated. Although the timing, background and other details have varied from country to country, the principles of the welfare

state reforms have been the same. What is shared is the idea of the need to restrain the size of the public sector (e.g. Hellman, Monni & Alanko 2017 *forthcoming*). All countries have employed different ‘activation’ policies intended to increase the numbers in the workforce on the labour market, often combined with a ‘workfare’ approach, meaning a policy that those who are receiving welfare benefits are expected to work (Substudy III). Moreover, the systems have strengthened the insurance principle, which refers to income-related social security and an emphasis on returns, as well as cost containment, decentralisation and privatisation of health care and social services (e.g. Kananen 2011; 2014; Kildal 2001; Nordlund 2006). Other major issues have been the reduction of national decision-making power as a result of the increasing public debt, the liberalisation of the financial market and the decision on the part of Sweden and Finland to join the European Union in the 1990s (e.g. Julkunen 2001; Christensen & Markkola 2006; Sulkunen 2015).

In Finland, the welfare state reform policies emerged in the context of an economic recession in the early 1990s. The change during and after the late 1990s has been described as a shift from universalistic public service to a mixed-service provision in the public sector in partnership with the private sector or with civil society organizations in the provision of services (see, for example, Julkunen 2001; Sulkunen 2006). Hiilamo (2014) conceptualises the development after the 1990s as ‘permanent austerity’: the crisis in the early 1990s caused by a steep recession was followed at the end of the 1990s and later in the early 2000s by policies that have paradoxically required participation in working life despite a high rate of unemployment. He further argues that successive Finnish governments have made deliberate choices not to reverse the cutbacks in social security, which together with the low taxes and rising income levels have increased inequality between those who are participating in working life and those who are not (Hiilamo 2014).

Other studies analysing the welfare state in Finland have pointed out that the restructuring has led to devaluing equality and to a shift towards workfare (Kananen 2012; Substudy III; cf. Holmqvist 2010). The change in the welfare system has also been analysed in terms of the welfare state’s promises of social security and how the promises were broken in post-1990s Finland, leading to ‘unbearable’ circumstances in individuals’ lives in situations of illness and unemployment, particularly when benefits were allocated according to the position in the labour market (Metteri 2012). Many have also pointed out that in the post-1990s welfare states, Nordic state citizens have not been regarded as political actors, but rather as ‘clients’ and ‘consumers’, that the ‘new’ Finnish welfare system demands increasing abilities from citizens and/or the recipients of the services, and that the new arrangements may increase inequality (e.g. Leppo & Perälä 2009, Ollila & Koivusalo 2009, Outinen 2012; in mental health care, Helén 2011a). Regardless of the interpretation of the exact timing of the change, previous studies have established that the Finnish welfare policy has changed profoundly. Previous studies are also fairly unanimous in agreeing that the changes cannot be explained only by the

financial crisis of the early 1990s, but that broader political changes had been at work. Moreover, even if the Finnish recession in the 1990s had a measurable impact, it also seems to have been used to justify ideological changes in welfare policy (e.g. Julkunen 2001; Outinen 2015).

From the point of view of mental health care and policy, two especially important events took place during the restructuring of the 1990s welfare state (e.g. Hyvönen 2008). The first event occurred in 1991, when the new Finnish Mental Health Act (1990/1991), the result of work that was begun in the 1960s, took effect. The amendment to the law should, however, be viewed as independent of the fluctuations in the welfare state context as the modification was planned during the phase of an expanding welfare state, but implemented during the economic crisis of the early 1990s.

The second event was the loss of a separate administration for psychiatry as a result of a reform in the administration of health care in general (Specialist Health Act 1989; Kärkkäinen 2004). At the most general level, a 'state subsidy reform' was carried out, which resulted in the state no longer being able to steer healthcare provision, but only provide information to the municipalities on how they should organise treatment provision. The responsibility for organising health care shifted to the municipalities, and the change from centralised planning to state information steering followed (e.g. Sulkunen 2006; Kröger 2011; Alavaikko 2007).

These reforms meant that, since 1993, the Finnish state has only been able to provide steering guidelines, and municipalities have been the responsible jurisdictions for implementing services. The implication of this circumstance for the topic of this study is that, from then on, the documents published at the state level about mental health were recommendations, not rules. This difference is highly visible in the data: in the documents prior to this change, the documents (particularly NBOH 1977; cf. Substudies I and IV) offered exact plans for resource allocation; towards the latter phase, this was not done. Discursively speaking, the policy documents analysed in this study began to operate more by describing situations, proposing solutions and steering the municipalities towards them instead of regulating exactly how the municipalities should take care of the citizens' mental health.

2.3 SUMMARY ON DEHOSPITALISATION AND WELFARE REFORMS

Nordic welfare states strive for universalism and increasing the equality of their citizens. Even though Finland may have been less far-reaching than its Nordic neighbours in its implementation of this principle, the Finnish social policy still has had the aim of following these principles. The welfare system has seen profound transformations since the 1990s, although the exact timing can be debated. However, the Finnish welfare policy is also outspokenly striving towards greater equality in health outcomes and health care. However,

in practice the unequal provision of health care is likely to increase the inequities (e.g. Kalliomaa-Puha & Kangas 2016). This may be particularly challenging in the field of mental health where part of the problem may relate to the ability to see and pursue what is in one's own best interest.

Dehospitalisation springs from criticism of psychiatric hospital care, which has been seen as worsening instead of improving patients' health and declining their likelihood to be able to function in society after treatment. Various factors have contributed to dehospitalisation in mental health care, such as the interests of the welfare policy or the psychiatric profession, the development of antipsychotic medication, the change in the perception of citizens and their criticism of psychiatric practices. Finland has been a latecomer to this issue, as the number of hospital beds only started to accumulate at a time when these numbers were decreasing elsewhere. However, once begun, the decrease was rapid. How much psychiatric hospital treatment *per se* has been reduced is a matter of debate: major changes seem to have taken place in durations of hospital treatment, but not in hospital admissions. Even though the policy of dehospitalisation has been largely agreed upon, the way it has been implemented has received constant public criticism, with questions raised about whether the current mental health care system provides adequate support and whether the new residential care facilities for psychiatric patients or to an increasing degree those in prisons are less 'institutionalising' than the previous arrangement in psychiatric hospitals.

It has sometimes been argued that psychiatric dehospitalisation is a result of welfare state restructuring or 'retrenchment' (for example, Nordlund 2005, 78). However, this notion must be problematised, as the relationship is more complex. To begin with, the development of avoiding the institutional care of mental health patients started during the 'golden age' of the welfare states and does not strictly correlate with aims of public spending curtailment. Studies on dehospitalisation have emphasised that the relevant background is to be found in multiple trends and not in single ones, such as economising public spending.

3 THE EXPANSION OF MENTAL HEALTH CARE

The British sociologist Nikolas Rose has pointed out that mental health problems in the 2000s seem to have no borders and that the practice of psychiatry seems to expand accordingly (Rose 2006). This section discusses a related phenomenon which I have decided to call the 'expansion of mental health care'. With the concept I am referring firstly to the expansion of what is understood as belonging to the jurisdiction of mental health care and secondly to a complex including a simultaneous growth of the provision, use and demand for mental health care.

The dehospitalisation policy discussed in the previous section was supported by negative images of psychiatric treatment and particularly by the idea that psychiatry used power in a repressive or otherwise inappropriate way (cf. Substudy I). Based on what is known about the development of the welfare state in recent decades and about dehospitalisation in the mental health sector as discussed in the previous section, one could perhaps expect that use of psychiatric services would have diminished along with dehospitalisation. Somewhat paradoxically, the demand for mental health care has increased. As the number of hospital beds has been reduced, the consumption of other mental health services has increased (for the situation in Finland, see Helén, Hämäläinen & Metteri 2011; Järvelin 2016; Wahlbeck 2007).

Mental health policies today often explicitly argue that mental health problems have not been paid enough attention – an argument that has been pronounced in particular by the European Commission (EC 2005; 2008) and the World Health Organization (WHO 2001; 2004; 2015; Vilhelmsson 2014). Another related phenomenon is the expansion of focus broadening from treating illness or disorder to including the promotion of mental health (for example, Helén, Hämäläinen & Metteri 2011; cf. Markström 2014; Bergmark, Bejerholm & Markström 2015; cf. Conrad & Schneider 1992, 66–67).

The expansion means that the use of and demand for outpatient care for a variety of illnesses, particularly depressive disorder, has increased, and the demand for outpatient mental health care has grown in a much wider share of the population, a large number of whom have never had any previous contact with the psychiatric hospital system (cf. Helén 2011 b, Wahlbeck 2007). The expanded demand for mental health care has been recognized both in Finland and internationally.

This section presents some partly alternative and partly overlapping explanations for this expansion. The starting point is that the expansion of the demand, provision and scope of mental health care are existing empirical phenomena that are unlikely to result from an increase in mental illness per se (Busfield 2012). In previous studies the emergence of new, healthier groups needing mental health services has been understood as being connected with

the medical (or other mental health professionals') authority, which imposes its views and translates these into new behaviours. This expansion has been seen as a 'manipulation', 'psychiatrisation' or 'medicalisation'. The increase in demand for mental health care is partly congruent with the mental health policy rationale analysed in the current study: in the documents promoting dehospitalisation, a core aim was to replace institutional treatment with outpatient treatment. There are, however, several indications that much of the outpatient care in Finland has not 'replaced the former institutional treatment' as planned in the policy proposals forming the data analysed in this study, but may serve an entirely new goal, namely supporting the employability of a somewhat select group of citizens.

3.1 THE EXPANSION IN NUMBERS

As discussed in the subsection 2.1., a relatively wide-scale trans-institutionalisation seems to be going on in Finland (Sotkanet 2017; Wahlbeck et al. 2017). Today in addition to approximately 3,000 psychiatric hospital beds, there are approximately 8,000 beds in residential care facilities targeted for those experiencing mental health problems. In addition, the use of psychopharmaceuticals has escalated; in Finland today as many as 789,000 people consume psychoactive drugs (Partio 2016; although the number has decreased slightly in recent years; Saastamoinen 2016).¹⁰ The use of psychotherapy primarily intended to enable patient employability has multiplied by fifty, from approximately 600 in 1980 to approximately 27,000 (NII 2016 a; b),¹¹ even if one counts only publicly-subsidised psychotherapy, which excludes information on out-of-pocket use of private mental health services (Partio 2016; Substudy IV). The escalation of the provision and use of psychotherapy is a sign that the provision of mental health care has increased. Yet more and more, that care is directed towards employability and less towards those suffering from conditions that previously would have been treated in hospitals. Being perceived as able to work is an official condition for receiving a public subsidy for psychotherapy (NII 2017; *Suomen Kuvalehti* 2016).

Another reason that mental health policies have evoked so much recent interest is that disability pensions related to mental health problems grew drastically from the mid-1990s up until a few years ago. Two major groups are represented in these statistics: those suffering from conditions understood as 'severe' and long term, such as psychoses or intellectual disability, and who often retire at a young age and without a significant working history; and those retiring with a diagnosis of depressive illness, who often have a relatively long

¹⁰ The treatment of depression is often carried out by general practitioners, not only by psychiatric specialists (Hautamäki, Helén & Kanula 2011; Olafsdottir 2010).

¹¹ This means that the use for subsidized psychotherapy has multiplied by 25, i.e. relatively speaking, much more than the number of psychiatric hospital beds.

working history. On the policy level, particular attention has been paid to the latter group, which is further discussed in Substudy III.

3.2 ACCOUNTS OF THE EXPANSION

Various explanations have been given for the increase in mental health care provision, use and demand, but these remind of each other in at least one respect: as mentioned above, it seems unlikely that the expansion resulted from a worsening state of mental health in absolute terms (Busfield 2012).

The increasing popularity of mental health care was noted already in the beginning of the period analysed in this study and addressed. As early as 1964, it was noted that Finnish psychiatric hospitals attracted a new group of voluntary patients (CR 1964; Substudy IV). The phenomenon here referred to as the expansion of mental health care has been addressed in several earlier studies, both in Finland (for example, Helén, Hämäläinen & Metteri 2011; Helén 2011a) as well as internationally (see, for example, Rose 1986; 2006, Vilhelmsson, Svensson & Meeuwisse 2011; Castel, Castel & Lowell 1982, Furedi 2004; Olafsdottir 2011).

In previous discussions these kinds of developments were often framed in an explanatory narrative of some sort of subordination practised by psychiatric professionals, even if the clientele was voluntary. In terms of 'psychiatric manipulation', 'psychiatrisation' or 'medicalisation', the professionals have been seen as steering the understanding of mental health and leading people to seek treatment that they could do without. For example, Castel and colleagues argued already in the late 1970s in the US that the scope of psychiatry had been extended to 'normality' and the 'normal' are manipulated to seek help by the psychiatric profession (Castel, Castel & Lowell 1982). The oldest of such discussions are those emphasising the socially constructed nature of mental health problems in terms of critical psychiatry (cf. subsection 2.2).

Later, in the 1980s and 1990s, Nikolas Rose argued that some decades before there had been a general interest in the 'psy-' sciences, primarily psychology and psychotherapy, which affected the understanding of the self (2006; 1999a; 1996). Rose has continued, however, to argue that the interest, popularity and impact on the 'psy-' has been complemented with the 'neuro-', partly because of the spreading of the use of neurochemicals (2004), with a focus on the brain stemming from neuroscientific advancements (Rose & Abi-Rached 2014). What these accounts have in common is that they draw on a crucial social scientific discussion about how the mind is being conquered by expert conceptualizations.

The Finnish researchers Helén, Hämäläinen and Metteri (2011) argue that the current paradox of the simultaneous increase of supply, but even greater increase in demand is due to the historical background of psychiatry, with its

two streams – what they call the ‘psychiatric-medical’ and the ‘social-structural’ – with the demise of the latter in favour of the former. These authors argue that current Finnish psychiatry reflects the ‘psychiatric-medical’ stream, which sees mental health problems as dwelling within the individual and treatable with pharmaceuticals. They further argue that the social psychiatric approach to mental health was never fully tried, but was overrun early on by an approach that focuses on individuals and a tendency to prescribe pharmaceutical treatment.

Another viewpoint has highlighted the increase of available psychiatric diagnoses. A phenomenon that is partly overlapping and partly independent of the discussion presented above is the shift from psychoanalytic psychiatry to ‘diagnostic psychiatry’. In the days of mass dehospitalisation in the US, the main form of available outpatient treatment was psychoanalysis (Mayes & Horwitz 2005; Horwitz 2002). The diagnostic classification in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders*, known as DSM-III¹² (published in 1980; the former versions I and II relied on psychoanalysis as well) with an effort to categorise mental disorders was an attempt to increase the reliability of diagnoses.

Horwitz argues that the aim of such an approach was to answer the needs of the patients released from psychiatric hospitals who could not be helped by psychoanalysis, as they were perceived too ill. Even though the analysis highlights the increase in the number of identifiable psychiatric patient diagnoses and the spread of these diagnoses to groups that would previously not have been perceived as psychiatric patients, this argument differs from ‘medicalisation’. These studies namely accept that the number of diagnoses have increased, but they argue that minor everyday problems were already recognized in the realm of psychiatry during the era of psychoanalysis (Mayes & Horwitz 2005).¹³ Even though today two major revisions have been conducted on the DSM-III and the version applied is the DSM-V, the analysis of diagnostic psychiatry still holds and has even become more topical as the subsequent editions DSM IV and DSM-5 contain more diagnoses than the DSM-III (for a critical discussion of the DSM-5, see e.g. Hacking 2013).

While the increasing number of psychiatric diagnoses does not necessarily draw new states into the field of medicine, as the term medicalisation would imply, the increasing amount of psychiatric diagnoses may well give way to pharmaceuticalisation, meaning the increasing treatment of conditions already understood as medical with pharmaceuticals (e.g. Abraham 2010). The pharmaceuticalisation of treatment has been of particular concern in the

¹² The DSM is a product of the American Psychiatric Association, but it has a major global effect. Finnish health care officially uses the ICD coding system produced by the WHO, but the principle, namely the aim of categorizing mental disorders, is the same. According to Hautamäki (2016), the DSM is in practice applied in many countries officially relying on the ICD classification, like Finland.

¹³ This may apply to some degree in Finland as well; for the remarkable role of psychoanalysis in psychotherapy until the 1980s, see Tähkä 1983, Alanen & Achté 1983, Pykkänen 1983.

treatment of clinical depression and related SSRI-antidepressants,¹⁴ and has been widely criticized (e.g. Busfield 2015; Hautamäki, Helén & Kanula 2011).

A noteworthy aspect of the increasing pharmaceuticalisation of mental health care is that it has enabled a transfer of many patients with mental health problems to the sphere of primary health care and general medical practice instead of secondary health care and the psychiatric specialty (e.g. Olafsdottir 2011). Moreover, the current clinical practice guidelines issued by the Finnish medical authorities recommend a combination of psychotherapy and pharmaceuticals for the most common mental health problems including. It should be noted that the combinations in the treatment seem not to have materialised: of the number of people taking antidepressants is approximately ten-fold compared to the number receiving subsidised psychotherapy for the treatment of any given mental health disorder (Partio 2016). This, of course, raises questions about the pharmaceuticalisation of mental health care.

Advertisement for SSRIs in the US have been viewed as recruiting new users by misrepresenting less serious conditions as needing treatment (e.g. Smardon 2007). Perhaps the most profound arguments in the criticism of the SSRIs are the following: their promotion has been seen as manufacturers' pursuit of economic profit; they have demonstrated that they are no more efficient than placebos in the treatment of depression; and, at their worst, SSRIs may even be dangerous for metabolism and for elevating the suicide rate (Charland 2013; Healy 2006 a; b; Gotzsche 2015). Moreover, it has also been pointed out that the development of the SSRI medicines has ceased, which should be interpreted as an indication of loss of hope in their potential to improve (Healy 2006a; b). Indeed, the SSRI pharmaceuticals have been cited as an extreme case illustrating how the pharmaceutical industry affects research and scientific publication, a matter that has been discussed as a threat to the integrity of psychiatry as a field of science (Charland 2014).

In analysing the impact of the environment on the demand for mental health services, many researchers, such as Ehrenberg (2010/1998), Helén, Hämäläinen and Metteri (2011), Teghtsoonian (2009), Esposito and Perez (2014) and Prins et al. (2015), have put forward arguments that today's neoliberal individualist society may increase the tendency to experience life challenges as personal problems and hence as being within the sphere of mental health. Many argue that this pertains particularly to the relatively affluent and educated middle class (see especially Mayes & Horwitz 2005, Wahlbeck 2007; Rosenfield 2012).

Historically psychiatry seems to have practised social control of the underprivileged (e.g. Ahlbeck-Rehn 2006; Shorter 1998). However, this seems hardly the problem any more. Mental health services seem to be used and to appeal to the middle class. It should be asked, whether the flipside of this exclusion of the underprivileged from treatment (cf. Lincoln 2006; Holman 2014)?

¹⁴ Selective serotonin reuptake inhibitors, often referred to as 'third generation antidepressants'.

3.3 SUMMARY ON THE EXPANSION OF MENTAL HEALTH CARE

The section above has discussed the current situation in mental health care, where the endeavour to minimise institutional treatment has ended up in a situation where the transinstitutionalisation from psychiatric hospitals to different residential care facilities and even prisons decreases the significance of dehospitalisation.

Moreover, a more or less new group of service users has emerged in mental health services broadly understood, because a significant number of these mental health problems are treated in general medicine in primary care. This, however, is not the only expansion of mental health care. Another expansion has become a new focus in mental health care, namely the rise and promotion of mental health instead of focusing on illness or disorder.

The section has discussed this expansion both in light of the numbers and the previous interpretations. It has been pointed out that many of the interpretations have tended to focus on the role of the professions, be they psychiatry or pharmaceutical manufacturers. Moreover, I have attempted to point out that in terms of the use of power, the new situation is somewhat different: whereas during the asylum era psychiatry may have been criticised for repressing the lower classes, people using the services today often seem to belong to the middle class and use the services voluntarily. Many previous studies appear to show that the new, heightened demand for mental health care seems to stem from a relatively healthy, relatively educated middle class.

4 THEORETICAL AND METHODOLOGICAL STARTING POINTS

The study analyses the welfare state from a cultural point of view (Autto & Nygård 2015) and has been theoretically inspired by two traditions of discussing the relationship between governance, the individual and public power. The cultural studies approach analyses the welfare state from the point of view of discourses, values and knowledge that are seen as crucial to the ways the welfare systems are constructed and operate.

One starting point stems from Michel Foucault's later work on governmentality, whereby the understanding of power is 'stimulation', not repression. This power is understood to be practised by institutions, discourses and knowledge (Foucault 1991a, 91–104). This way of using power has been understood as 'biopower', which is intended to increase the strength of the governed and hence to enhance their vitality (Helén 2016; 2010; Rabinow & Rose 2006; Foucault 1998[1976]; Nadesan Holmer 2008). Power is seen as enabling people, yet not to anything but particularly to ends set in governing. According to Rabinow and Rose (2006), such power works by means of truth discourses, strategies for intervention and enabling suitable modes of 'subjectification'. The governmental rationalities shape the subjects or rather act in co-operation with the subjects themselves; hence, a crucial part of the analysis is to identify the kinds of subjects each governmental rationality constructs and enables.

A second starting point has been influenced by Pekka Sulkunen's work on autonomy and its endogenous conflicts in today's society (Sulkunen 2009; 2011; 2016). What is of particular value is the way Sulkunen discusses how citizens are viewed in current policies. He argues that in today's societies, autonomy is a central principle of belonging, the flipside of which is the possible loss of dignity and the marginalisation of those who are unable to practise autonomy (2011, 5–11; 2009, 53–75). Sulkunen's starting point is state intervention. He argues that today, the state has a hard time justifying interference in what citizens do with their health, and the state cannot affect citizens' choices, even if those choices are harmful. In the context of mental health, this can be perceived, for example, in the ethical problems that relate to the legitimacy of interfering in a person's life in the event of mental health problems (Peele & Chodoff 2009). Sulkunen also stresses that today the autonomous individual needs 'intimacy', the sense of a separate selfhood and authenticity, which still draws on shared cultural material. As a result of the contradiction between autonomy and intimacy, the state risks overemphasising intimacy and failing to support the pursuit of autonomy, as people are to be governed in ways that acknowledge the view of individuals as free and unique. This approach particularly concerns groups with vulnerable agency such as substance abusers as well as people with mental health

problems. The proliferation of autonomy today is seen as a result of the protest movements of the 1960s, which highlighted the freedom of the individual. One of these movements was the November Movement, which has provided one of the historical starting points for the current study.

These theoretical frameworks were chosen for their potential to help understand the way governing affects and constitutes subjects. The concept of autonomy has made it possible to analyse a conflict inherent in mental health problems between equal citizenship and particularities that may complicate the autonomy of the citizen.

The analysis, which draws on the methodological literature for governmentality (Bacchi 2009) and semiotic sociology (Sulkunen & Törrönen 1997a; b), focussed on representations of the problem in the core of the policy proposals. First, influenced particularly by the approach suggested by Carol Bacchi, the analysis sought to determine what each Finnish mental health policy document considered to be the problem, and hence the reason that mental health care was seen as needing reform. Second, influenced by both traditions, the analysis focused on understanding the subjectivities of people influenced by mental health policy. Last, as suggested by Bacchi, the conclusions of the study also discuss what the policies do not problematise; in Bacchi's terms, the 'silences' of the proposals.

5 DATA AND ANALYSIS

The data analysed here are Finnish governmental level mental health policy documents from 1964 to 2015. Although Finnish municipalities are relatively independent in making decisions about service provision,¹⁵ the general planning and steering of mental health care has been a task at the governmental level (Mental Health Act 1991). The documents were examined to determine the rationale the policy documents reflect and the kinds of subjectivities that the rationale enables. By rationale, I am referring to an overall way of thinking and reasoning within the policy proposals suggesting how reform mental health care.

In selecting the data, I made a robust distinction between ‘general level’ mental health policy issues and the discussion of ‘particular policy issues’. By general level mental health policy documents, I refer to the planning related to all mental health questions or issues in the population as a whole. The majority of Finnish mental health policy documents can be considered to represent this category. In the cases of Substudies I and IV, I focussed on the general level mental health policy documents. Substudies II and III analyse policy documents for programmes that concentrated on a ‘particular issue’, namely the development of schizophrenia care (Substudy II) and early retirement due to depressive disorder (Substudy III). The research has been carried out in the form of four substudies.

The analysis has been conducted by reading the policy documents several times, making notes about the basic ideas expressed there and identifying the excerpts that articulate the rationale for reform. Particular attention was given to the ways in which mental health service users and/or the policy target group were discussed, and these passages were further analysed. An initial attempt was made to conduct the analysis using ATLAS/TI. However, the use of the software resulted in fragmentation of the data and ended up analytically unproductive in the attempt to grasp the overall rationale of the documents.

The data (see Table 1) were viewed as representing the rationale at the time the policy proposals were issued. The author of the policy documents was sometimes named (for example, in ‘Taipale 1996’), but often the publication was under the name of an administrative body. In most documents the working group presenting the suggestion was named (for example, in CR 1984, dozens of members of the working group are listed). In line with the tradition of governmentality studies, the author of the text was de-emphasised, and the data were read as representative of a broader rationale.

The data were analysed to determine the aims of the governance modes envisioned and the implications for power relations. What kinds of proposals were made to improve mental health care? And what subjectivities were

¹⁵ This situation will change with the social and health care reform that will be enacted in 2019.

possible and brought to the fore in the proposals? This approach helps to understand the ways in which governance affects and constitutes subjects.

As stated, most of these documents were largely written by groups made up of dozens of people representing different stakeholders and societal sectors. While the impact of a secretary who chooses to include some issues in the minutes while excluding others is likely to be remarkable to some extent, the documents probably reflect rather well the issues shared by group members in their conversations, probably better than individual interviews. Sometimes when there have been strong 'dissenting opinions', these have been separately attached to the resolution (for example, in the case of the importance of social work in mental health care; CR 1984).

At the start of this dissertation four key informant interviews were carried out with persons who had been working in at least one of the groups producing the documents. These interviews were very important as means of understanding the field, in gaining basic knowledge of the developments and in assessing the importance of each policy document in the data. Still, the documents turned out to be more fruitful material for the analysis, as they enabled a grasp of the policy rationale in the form it was originally presented. Analysing the documents hence enabled an analysis of the change in policy by comparing rationales at different times, whereas the interviews on history contained a great deal of reflection on today's situation in discussions of the past.

Table 1 Data

Abbreviation	Sub-study	Title	Background and aim
CR1964	IV	Committee Report	Report from a committee that was appointed for renewing the Mental Illness Act of 1953.
GP1976	IV	Government proposal	Government bill for changing the contents of the Mental Illness Act.
NBoH 1977	I, IV	National Board of Health working group memorandum 1977	A memorandum of a task force appointed to renew Finnish psychiatric health care.
NBOH 1981	II	Schizophrenia project: Proposal for working plan	A document planning the ‘Schizophrenia project’.
CR 1984	I, IV	Committee Report	Committee report (approx. 800 pages) reviewing the history, current situation and the ideal future of mental health in Finland, including a proposal for a new mental health care work act.
NBOH 1985	II	Skitsofrenian hoidon valtakunnallinen kehittäminen – Válráportti	Interim report of the ‘Schizophrenia project’.
NBOH 1988	II	Skitsofreniáprojekti 1981–1987. Skitsofrenian tutkimuksen, hoidon ja kuntoutuksen valtakunnallisen kehittämisohjelman loppuráportti	Final report of the ‘Schizophrenia project’.
GP 1989	IV	Government proposal 1989	Government bill suggesting a shift to the Mental Health Act.
Taipale 1996	I, IV	Meaningful Life report	A one-man committee report by Vappu Taipale regarding the situation of mental health care in Finland after the 1990s recession.
MSAH 1997	I, IV	The pre-plan of the Meaningful Life project	A document setting the agenda for the Meaningful Life!-project based on the one-person committee work (Taipale 1996)
MSAH 2000	I, IV	Meaningful Life: Development recommendations for mental health services	Interim recommendations of the Meaningful Life!-report
MOL 2001a	III	MOL (2001a) Guidelines. Clarifying the preconditions for pensions for the long-term unemployed. Helsinki: Ministry of Labour.	Guidelines for street level bureaucrats on implementing the ‘Pension is a possibility’ programme.
MOL 2001b	III	Setting decision. National steering and follow-up group for clarifying the preconditions for pensions for the long-term unemployed. Helsinki: Ministry of Labour.	Setting decision of the ‘Pension is a possibility’-project screening those entitled to disability pension from the group of the long-term unemployed.
MSAH 2002	I, IV	From Structures to substance, from words to actions! Mental health in primary services – Swallow	End report from a programme suggesting education in mental health work for all social and health care frontline workers.

MSAH 2003	I, IV	Meaningful Life! programme 2003	End report from the Meaningful Life programme intended to solve the problems generated during the recession.
MOL 2003	III	Summary of clarifying the preconditions for pensions for long-term unemployed in the follow-up period 1 January 2001–21 December 2002. Helsinki: Ministry of Labour.	A follow-up report of the Pension is a possibility-report
FCP 2004	III	Mielenterveys ja työkyvyttömyyseläkkeet.	A report analysing mental health-related disability pensions.
Motion 2004	I, IV	Mental health programme	A parliamentary motion suggesting a mental health programme.
MOL 2004	III	Guidelines. Clarifying the preconditions for pensions for the long-term unemployed. Helsinki: Ministry of Labour.	Updated guidelines for street level bureaucrats on implementing the 'Pension is a possibility' programme.
MSAH 2005	III	Mental health disorders as reasons for early retirement: Aspects of prevention, treatment and rehabilitation	A memorandum intended to prevent mental health-related early retirement.
FCP 2007	III	Why does depression lead to early retirement?	A memorandum analysing early retirement with a focus on depression.
MSAH 2008	III	The action plan of the MAST project. A project intended to prevent and reduce depression-related early retirement	A programme intended to prevent depression-related early retirement.
MSAH 2009 (original)	I, IV	MIELI 2009 [The Mind 2009]. Plan for mental health and substance abuse work 2009–2015.	National policy programme intended to renew mental health care according to the needs of the Finnish population. Includes a suggestion for merging mental health and substance abuse care.
MSAH 2010			
(English translation)			
MSAH (2011)		Final report of the Mast programme. Actions and proposals of the project to reduce depression-related work disability.	Final report of the Mast programme.
NIHW 2015	I, IV	Plan for Mental Health and Substance Abuse Work 2009–2015. How to proceed from here?	Final report of the MIND programme.
MSAH 2016	I, IV	Plan for mental health and substance abuse work for 2009–2015. Final assessment of the plan and proposals by the steering group	Assessment report containing both the assessment of the programme's steering group as well as the assessment of exterior experts.

6 SUBSTUDIES

This section introduces the four substudies. Substudies I and IV discuss Finnish mental health policy on a general level, whereas substudies II and III focus on two particular problems. The focus of substudy II is on the rehabilitation and dehospitalisation of patients diagnosed with schizophrenia, and the focus of the article III are the fluctuations of the notions of unemployment and disability.

6.1 SUBSTUDY I: 'WHO NEEDS MENTAL HEALTH SERVICES?' ¹⁶

The first substudy analyses the most important planning documents behind the psychiatric dehospitalisation policy (NBoH 1977; CR 1984; Taipale 1996; MSAH 1997; 2000; 2003a; 2009; 2010). The research questions were:

I What have been the key aims and proposals for Finnish mental health care planning between 1977 and 2009?

II What is the image of the service user, and what abilities and responsibilities have the plans assigned to service users?

The analysis suggests that the documents across these years repeat the same suggestions on how to improve Finnish mental health care: all propose to improve care by decreasing excessive psychiatric hospital treatment, increasing outpatient mental health services, boosting the potential of mental health service users to take part in working life, increasing the equality between mental health patients and other citizens, following international examples on how to organise mental health care and defining the core group for mental health care. These six repeated suggestions are called the 'revolving aims' of mental health policy.

When the analysis focussed on the core group, however, another result emerged: despite the revolving aims, documents from different periods perceived mental health service users differently. In the beginning of the period studied here, service users in the late 1970s were represented mostly as 'patients' in need of care, while towards the end, in the 2000s, they were portrayed as autonomous 'clients'. The question posed in the substudy title –

¹⁶ Alanko Anna & Carl Marklund (2013). Who needs mental health services? The aims and the service user images in Finnish mental health care planning. In Marklund, Carl (ed.), 'All Well in the Welfare State? Mental wellbeing and the politics of happiness', NordWel Studies in Historical Welfare State Research, pp. 82–102.

who needs mental health services? – is answered by pointing out that, by viewing the target group for mental health care planning as autonomous, clients may arrive at the notion that no-one needs mental health care services, even though the demand for services is high. The substudy concludes by discussing how the shift in perception of those using the services is related to different periods in the welfare state. It also discusses the effect of the recent emphasis on the autonomy of service users and its potential effect on the allocation of mental health care.

6.2 SUBSTUDY II: ‘FROM A VIRTUOUS CIRCLE TO AN AUTONOMOUS LIFE’¹⁷

The starting point of the second substudy is that previous analyses have argued that the recent welfare state reforms have increased citizens’ responsibility for independent coping and autonomy. The substudy explores the phenomenon by analysing a project conducted in the 1980s that focused on the research, treatment and rehabilitation of a condition considered a serious mental illness, schizophrenia. This project, ‘The National Schizophrenia Project’ (hereafter ‘Schizophrenia project’; NBOH 1981; 1985; 1988), dates back to the so-called ‘golden years’ of the Nordic welfare state in Finland, a time of the expanding welfare state.

The key aim of the Schizophrenia project – to reduce psychiatric hospital care – is discussed as being both concurrent and conflicting with the welfare state policy of the ‘golden years’. On the one hand, cutting down on institutional treatment can be seen as typical of post-expansive welfare state logic (cf. subsection 2.3), yet on the other hand, the Schizophrenia project intended to provide a number of services to replace psychiatric hospitals. The research question was:

I How was the autonomy of patients perceived as severely ill pursued in Finland in the mid-1980s?

II Was the pursuit of autonomy in the mid-1980s different from the ‘responsibilisation’ of citizens perceived in previous studies?

The analysis sought to determine whether the rationale of the Schizophrenia project, which attempted to avoid unnecessary psychiatric hospital care, reflected a shift in the responsibility for independent coping to citizens themselves.

17 Alanko, Anna (2015). ‘Hyvältä kehältä autonomiseen elämään’. In Autto, Janne & Mikael Nygård (eds) *Hyvinvointivaltion kulttuurintutkimus* [Cultural studies of the welfare state]. Rovaniemi, Finland: Lapland University Press, pp. 167-195.

The dynamics between the need for care and the aspirations for autonomy appear in the documents of the Schizophrenia project as a virtuous circle. The project's most important goal was to increase the autonomy of the citizens suffering from schizophrenia as much as possible, but instead of requiring independent coping from citizens as a starting point, the Schizophrenia project discussed ways of caring for the sick to enable their autonomy by providing support. The support involved both prevention and rehabilitation. This pursuit of autonomy through a supported virtuous circle seems fundamentally different from the responsabilisation in the post-expansionist welfare states.

The conclusions, however, point out that the Schizophrenia project also perceived the relationship of state interference and the individual in a way that would probably be seen as problematic today. Several of its means, such as a normative emphasis on the importance of leading as 'normal' a life as possible and on heterosexuality as an indicator of good mental health, would today be considered overstepping the boundaries of people's right to intimacy.

6.3 SUBSTUDY III: 'DUALISING ACTIVATION'¹⁸

The starting point of this substudy was that Finnish mental health policy documents have often emphasised the need to create opportunities for patients to participate in working life (Substudy I). Paradoxically, disability retirement for mental health reasons has simultaneously grown in Finland. This paradox is analysed in the context of the global 'activation turn' in welfare states, which has been recognised in previous studies. The substudy discusses activation measures in two groups, the unemployed and those at risk for work disability due to mental health problems. The research question were:

I What subject positions are reflected in Finnish policies relating to unemployment and disability pensions after the country's recession in the 1990s?

II Do the policies enact dualisation between insiders and outsiders?

The analysis shows that activation measures practised in Finland around the dawn of the new millennium include tendencies that increase dualisation, i.e. classifying citizens' entitlements according to their labour-market status. In mental health policy, dualisation results from favouring groups whose distance from the labour market is the smallest and abandoning those without

¹⁸ Alanko, Anna & Sami Outinen (2016). Dualising Activation: Responses to unemployment and mental health-related disability retirement in Finland at the turn of the millennium. *European Societies*, 417–437. Sami Outinen conducted a separate case study on Finnish unemployment security policy. The data were the GP 338/1992; GP 235/1993 and the GP 72/1996.

education and a working history. The dualisation seems to have been made possible by characterising the disadvantaged as either ‘unable’ to work (in the case of mental health issues) or ‘unwilling’ to work (in the case of unemployment).

The substudy categorised activation measures as either ‘providing’ or ‘restrictive’. However, for a disadvantaged group with both long-term unemployment and severe health problems, particularly within a ‘Pension is Possibility’ project intended to identify difficult-to-employ individuals for early retirement (MOL 2001 a, b; 2003; 2004), the activation principle was discarded altogether. It was done by characterising the target group as ‘unable’ to work and shifting them from employment services to a minimum-level sickness pension. Some years later, when another policy project was set up to identify the favoured group, namely those closer to working life and also with conditions considered to be less disabling, the activation measures were ‘providing’, i.e. supporting patients to remain in the labour force (MSAH 2008; 2011).

Within the mental health policy, the favoured, meaning those with milder mental health problems, better education and a longer working history, were characterised as both willing and able to continue working. However, both their workplaces and the overall health care system were presented as lacking an activating approach. These measures in effect practised dualisation by marginalizing those who were further away from the labour market and blatantly favouring patients with a better connection with working life.

The rationales of allowing the disability retirement of the long-term unemployed and prioritising the protection of the working ability of those with less difficult problems and a longer working history contributed to further marginalisation of people suffering serious mental health problems from the labour market. Those deemed unable to work often ended up relying on basic-level income security considerably below the poverty line. Such measures conflict with several specific aims in the Nordic welfare states, such as universalism and decommodification, yet such a rationale was presented as a part of the mental health policy in Finland.

6.4 SUBSTUDY IV: ‘SERVICE USERS AND EXPERTS’¹⁹

The fourth substudy focused on the relationship between service users and experts in mental health policy from the mid-sixties to 2016. The starting points were the simultaneous trends of dehospitalisation and the increase in demand for mental health services. In previous studies the increase in demands and provisions has been labelled expertisation – either psychiatrisation or medicalisation. The substudy suggests that the previous

¹⁹ Alanko, Anna & Matilda Hellman (2017, forthcoming). ‘Service users and experts in Finnish mental health policies: Three phases of expansion and inclusion’. *Sosiologia*

interpretations should be rethought. The substudy analyses the problems presented in Finnish mental health policy documents in three different phases (CR 1964; GP 1976; NBOH 1977; CR 1984; GP 1989; Taipale 1996; MSAH 1997; 2000; 2002; 2003; Motion 2004; MSAH 2009; 2010; NIHW 2015; MSAH 2016) and focuses on notions of expertise and the position of service users. The research question was:

How do the Finnish mental health policy documents describe the relationship between ‘experts’ and ‘service users’ in the years from 1964 to 2016?

The analysis showed that, instead of an increasing medicalisation of the relationship between experts and service users, the developments seemed to highlight the expert role of the service users. In the beginning of the analysed period the challenge was how to be able to provide psychiatric services for a wider group of people. However, towards the end of the period, experts were no longer seen as knowing any better than other people what should be done about mental health problems, and service users were considered the experts in the area of mental health care.

On the one hand, the development can be seen as increasing democracy, but on the other hand, presenting the service users as ‘experts’ may misrepresent the questions relating to treatment access in mental health care. Towards the end of the period studied, the experts were no longer seen as knowing best what should be done about mental health problems, and by the end of the period, the service users were designated the experts in the area of mental health care. Finally, the substudy points out that *not providing expert services* may not be in the best interest of the service users.

7 RESULTS: REVOLVING PROPOSALS TO IMPROVE MENTAL HEALTH CARE

The study shows that the Finnish mental health care policy documents present similar suggestions from time to time over the course of the period analysed, but the overall welfare policy affects what the suggestions mean. The starting points for the study were the reforms in the Finnish welfare state and mental health care. These developments were further complicated with the emerging of the complex of the expansion of mental health care, referring to the widening use of and increased demand for mental health care as well as the broadening jurisdiction of the concept of mental health. Hence, the Finnish mental health care planning documents from the period make similar suggestions from time to time, but in different welfare state contexts.

One repeated suggestion stands out above them all: reducing psychiatric hospital care was proposed as a solution in all the documents as a means of improving mental health care. This suggestion was made regardless of what was seen as the core challenge, the 'problem' (Bacchi 2009) in such care: whether there were 'wrong' groups of people such as the elderly, the disabled or substance abusers in psychiatric hospitals (as in NBOH 1977) or whether it was deemed necessary to increase rehabilitation instead of long term hospital treatment (NBOH 1982, 1985, 1988) or to amend mental health care legislation (CR 1984) or to make up for savings carried out during the recession of the 1990s (Taipale 1996). In the end, reducing psychiatric hospital beds was somewhat paradoxically presented as a solution when the task was to 'supply all Finnish citizens the mental health care they need' (MSAH 2009; *Motion* 2014). In all these circumstances the primary means of improving mental health care was reducing the amount of psychiatric hospital care. The suggestion was independent of how many psychiatric hospitals there were and of how much these hospitals might already have reduced the inpatient psychiatric care they delivered. (See Substudy I, in particular.)

Second, the planning has repeatedly emphasised the need for mental health care service users to participate in working life. The emphasis on work starts from a utilitarian-seeming notion that psychiatric patients could work instead of lying in a hospital, and this would be beneficial to all, both the society and the patients themselves. In the days of the expansive welfare state, working was also considered to be therapeutic in itself, and therefore, providing 'sheltered work' with the aim of rehabilitation was deemed to be a worthy goal and a task of the health care system (CR 1984). However, in the post-1990s context, the suggestion of supporting working ability ended up legitimizing 'dualisation', classifying citizens and their access to welfare according to their perceived employability and position in working life. Moreover, starting from the mid-1990s, there was a significant group of people on disability pensions for mental health reasons, yet mental health services were still being provided

according to an individual's (potential) position in the labour market. The disability pension is an ambivalent form of social security: on the one hand, the disability pension is a form of securing a person's income. Moreover, those who have applied but not gained disability pension tend to be in a very disadvantaged position, and they rarely return to work (Kivekäs, Hiljanen & Kantonen 2012). On the other hand, those in a disadvantaged position are more likely to retire early for reasons of mental health, and the disability pension seems to deteriorate their mental health and even increase mortality (Leinonen 2014). Those on disability pensions are also excluded from a part of the health care services (Substudy III).

The rationale emphasising work effectively legitimised directing care to those who are able to work (Substudies I, III). Correspondingly it ignored those outside the labour market. In spite of the repeated proposals to increase the participation in working life from the mid-1970s onwards, today a remarkable share of or even most of the people diagnosed with schizophrenia continued to be on disability pension (Jääskeläinen et al. 2010). Moreover, even if the explicit aim of the policy proposals was at first to prevent the early retirement of all citizens, the aim was later shifted to preventing the early retirement of the relatively fortunate with less severe mental health problems and more integration into working life. For example, in the Schizophrenia project analysed in Substudy II, the focus was established as a mental illness that was perceived as a major problem for the health care system as well as a personal tragedy. In the project the planning was apparently geared to provide the whole spectrum of available support measures, from family therapy to guidance in using public transport (cf. Substudy II). One of the means for improving the situation for those suffering from mental health problems was always to increase their ability to engage in working life. However, in the documents from the beginning of the studied period the provision of services was not connected with an individual's likelihood of working in a job in the labour market; the idea was to provide patients with all the mental health care means at the state's disposal (Substudy II).

Third, the policy rationale also highlighted the autonomy of service users. During the first half of the analysed period, autonomy was the target of the dehospitalisation and the support given to the former patients, but it was seen the responsibility of health care to ensure that the patients' autonomy was enabled (Substudy II). In the second half of the analysed period, service users' autonomy came to be seen as essential, not gained through support. One of the origins of this notion seems to have been the perception of autonomy as a key aspect of being a respectable person *per se* (cf. Sulkunen 2009; 2016). The other potential source is the expansion of mental health care: as the group using and demanding mental health services has expanded, there may of course be an increasingly large group of fully capable actors in the sphere of mental health care. Still, the perception of mental health care service users as inherently autonomous may serve to understate the needs of mental health care service users in planning. Moreover, during the early days of

dehospitalisation, whose policy core was the neediest patients (cf. Substudy II), the autonomy of the patients was seen to emerge from a virtuous circle of support and successful rehabilitation. Today the patients needing support seem to have fallen off the agenda, strengthening the potential exclusion of the disadvantaged.

The emphasis on autonomy is also visible in the dynamics between need for care and expertise: the notion of the essentially autonomous service user is also reflected in how expertise was conceptualised. During the period analysed in the study, the understanding of who has the best expertise in mental health care issues shifted from professional psychiatrists via other welfare professions to service users, who were reconceptualised as the best experts on mental health services. The emphasis on the expertise of services users collides with the expanded demand for care. It seems that while the expansion of the demand for professional mental health care stems from the relatively healthy middle-class, the user expert position is offered to those with serious mental health conditions. (Substudy IV.)

The rationale presented in the documents ignores that expansion as well as the contradiction of user expertise in a situation of increased demand for help in mental health issues. By contrast, in the beginning of the period analysed here, the 1960s to the 1980s, the planning documents reflect a self-evident desire on the part of the state to take care of those perceived to be ill and in need of assistance. At first the idea was to additionally take into account the health of those who were not perceived to be ill, but who sought mental health services and whose mental health was understood to benefit from using these services (Substudies I and IV) – in addition to the care for the group perceived as ill and in need of help.

Towards the end of the analysed period, the focus on illness faded away, which may have lessened the centre of activity from caring for the neediest and, again, shifted it to the promotion of mental health and employability (Substudies I, II, III). Even though increasing equality among those suffering from mental health problems and other citizens was on the agenda of many of the policy documents (Substudy I), this seems to have materialised much less than the other revolving proposals.

The question on the silences in the policy proposals derived from the methodological approach suggested by Bacchi (2009) drew my attention to what the policy proposals did not problematise. I argue that they left the mental health of those perceived as ill and those perceived as unable to contribute to the labour market unproblematised (see Table I). I will further discuss this in the next section presenting the conclusions of this study.

Table 1: Revolving aims in Finnish mental health policy 1964–2016, their rationales and the silences

Revolving proposal	Rationale	What is not problematized?
Dehospitalisation	Avoiding unnecessary seclusion	Abandonment Re/transinstitutionalisation
Working ability	Work as helpful to all	The group unable to work in the labour market
Autonomy	People should decide for themselves	Not providing support
User expertise	The users have invaluable knowledge	High demand for mental health care

8 CONCLUSIONS: A NEED FOR PROTECTION FROM ABANDONMENT?

A key issue in dehospitalisation, both in Finland and elsewhere, has been the attempt to avoid interfering in people's liberty unless it is necessary. Both interfering in peoples' lives (an extreme example being long-term institutional treatment) as well as not interfering are profound ethical questions.

Mental health problems have historically been treated with methods that afterwards seem cruel. In the Finnish context, studies have been conducted, for example, on lifelong isolation (Ahlbeck-Rehn 2006), on the enforced sterilization of unwanted populations, including the mentally ill (Mattila 2003), and on the use of lobotomy (Salminen 2011). This history is very often referred to, and it was also brought up in some of the policy documents (particularly CR 1984) and in the interviews conducted as background for this study with people who had been key figures in the policy initiatives. It seems that the risk of interfering too much in peoples' lives was an important motivating force in the mental health policy reform initiatives. During the period analysed in the current study it seems that the importance of not interfering was a very strong principle in mental health policy.

At the same time as the excessive involvement in citizens' lives has been criticised, another remarkable phenomenon has been the expansion of the demand, use, provision, and jurisdiction of expert mental health care (Substudies I, IV; section 3 above). Particularly important is that this expansion seems to happen amongst the relatively healthy middle class. In the policy documents analysed for the current study this expansion was not acknowledged, and no suggestions were made for addressing the expansion. Yet the rationale still seems to employ avoiding excessive interference in citizens' lives as a core principle.

Nevertheless, at the beginning of the analysed period (CR 1964), a committee made a suggestion related to that very question: How should the system respond to voluntary demand for psychiatric hospital treatment? Today the question remains: What should be done about the demand for mental health care, which continues to exceed the care provision? There seems also to be a new question: are there groups that would benefit from mental health care but are unable to demand it?

In international studies several patterns have been found that we should take seriously. In a study of the use of talking therapies in mental health care, less educated people perceived talking as not being helpful at all (Holman 2014). Moreover, a 'care avoidance – care paralysis' complex has been found in public mental health services targeting the disadvantaged. This complex means that the most disadvantaged avoid the mental health care to which they have access, as they have had bad experiences, particularly as mental health

care is unable to deal with their complex problems (Schout, de Jong & Zeelen 2011).

In the social science on mental health, researchers have often criticised both the individualising of society and individualising treatment strategies (for a recent example, see Neitzke 2016; for an overview, see for example Scull 2015). There is no denying that the individualising society may be at least partly to blame for experiences of hardships such as unemployment as 'mental health problems'. What we know today as 'mental health disorders' does not necessarily consist of problems that should be taken care of by mental health professionals only or only by treating individuals instead of changing the social structures. Nevertheless, I argue that the mental health care policy should take into account two things: the expansion of the use and demand of professional mental health care and exclusion mechanisms in Finnish health care.

In addition to problematizing individual treatment instead of fixing the social structures, it also seems relevant to problematise the structures of health care. Today there are two fundamentally problematic ways of allocating health care that have not been effectively problematised in the documents analysed for this study. *Subsidised psychotherapy* is one example: acquiring it in Finland is a demanding process taking months and requiring a remarkable sum of money that will not be reimbursed (*Suomen Kuvalehti* 2016), yet nearly 30,000 people have taken the trouble to acquire this care (NII 2016a, Partio 2016). The other example is *occupational health care*, namely granting employed people free and most often very rapid access to health care. In addition it also appears that public secondary mental health care treats people in an unequal way based on their socio-economic position (Ostamo et al. 2005).

Currently, the Finnish health care system is completely dualised according to a person's position in the labour market (e.g. Vuorenkoski 2008, Substudy III, Sorsa 2011). The enormous health care reform in process will not alter this, despite outspoken aims of increasing equality (e.g. Kallioma-Puha & Kangas 2016). The dividing up of who is eligible for health care was not taken up in the mental health policy documents analysed in this study as being a problem, and the fact that occupational health care is available only to the employed was not addressed. On the contrary, the occupational health care was represented as a factor that aided patient rehabilitation (MSAH 2011). In addition, the outcomes of the disability retirement of the more marginalised were not addressed, even though it has been shown that disability retirement at an early age increases morbidity and mortality (Leinonen 2014). The availability of subsidised psychotherapy was improved during the period and the use of it became more common, but there was no discussion of extending its provision to persons not considered employable in the labour market.

The results of this study reflect a system in which conceptions of working ability, dehospitalisation, essential autonomy and 'expertise through experience' all contribute. The picture is one in which patients are not seen as needing help from the health care system as citizens, but rather as contributors

to the economy. Yet simultaneous with the aim of carrying out dehospitalisation has been the increase in the supply of mental health care services, partly according to articulated plans. However, this has taken place in a context that highlights the supply of labour for the market overall and provides health care according to individuals' position in that market. Thus, mental health care planning in Finland neglects the particular problems of the population targeted previously, namely those with long-term disabling conditions. Moreover, the concepts and rationales co-opted from the traditions of critical psychiatry and the user movement may be used to hide and legitimise this neglect.

Based on a study of admissions to a psychiatric emergency ward, Alisa Lincoln (2006) has pointed out that, instead of an understanding based on the history of psychiatry as repressing the underclass, which includes a view of hospitalisation as an act of social control imposed on a marginalised person with mental health problems, today the underprivileged are not as likely to be disproportionately treated; but rather a disproportionate number are kept outside treatment as a result of being perceived as the 'undeserving sick'. Hence, we should note that in today's circumstances, the harshest way of using power may be to downgrade the need to offer mental health services at all for the underprivileged.

Many have pointed out that the increased demand for mental health care may stem from the individualist times in which we live. It has also been shown, both in previous studies as well as the current study that the mental health care plans from the expansive welfare state period in Finland suggested social psychiatric means to improve the mental health of the population. These suggestions never materialised, and it does not seem that they will. Social interventions could possibly solve some of the issues related to excess individualism. If such radical reform is not planned, at least equal access to care should be ensured.

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